AMENDED IN SENATE APRIL 18, 2005

SENATE BILL No. 840

Introduced by Senator Kuehl
(Principal coauthor: Senator Ortiz)

(Principal coauthors: Assembly Members Chan, Goldberg, and Leno)

(Coauthors: Senators Alquist, *Cedillo,* Chesbro, Escutia, Florez, Lowenthal, Migden, *Murray,* Perata, ~~and Romero~~ *Romero, and Soto*)

(Coauthors: Assembly Members Berg, *Dymally,* Evans, Hancock, Jones, Koretz, Laird, Levine, Lieber, ~~and Pavley~~ *Nava, Pavley, Vargas, and Yee*)

February 22, 2005

An act to add Division 112 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 840, as amended, Kuehl. Single-payer health care coverage.

Existing law does not provide a system of universal health care coverage for California residents. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program administered by the State Department of Health Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would establish the California Health Insurance System to be administered by the newly created California Health Insurance Agency under the control of an elected Health Insurance

Commissioner. The bill would make all California residents eligible for specified health care benefits under the California Health Insurance System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. ~~The bill would impose limits on deductibles or copayments that the commissioner would be authorized to establish.~~ The bill would require the health care system to be operational within 2 years of enactment, and would enact various transition provisions. The bill would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California Health Insurance System, which would then assume responsibility for all benefits and services previously paid for with those funds.

The bill would create a health insurance policy board to establish policy on medical issues and various other matters relating to the health care system. The bill would create the Office of Consumer Advocacy within the agency to represent the interests of health care consumers relative to the health care system. The bill would create within the agency the Office of Health Care Planning to plan for the health care needs of the population, and the Office of Health Care Quality, headed by the chief medical officer, to support the delivery of high quality care and promote provider and patient satisfaction. The bill would create the Office of Inspector General for the California Health Insurance System within the Attorney General's office, which would have various oversight powers. The bill would prohibit health care service plan contracts or health insurance policies from being issued for services covered by the California Health Insurance System. The bill would create the Health Insurance Fund and the Payments Board to administer the finances of the California Health Insurance System. The bill would prohibit payment of shareholder dividends from system revenues by participating private companies. The bill would extend the application of certain insurance fraud laws to providers of services and products under the health care system, thereby imposing a state-mandated local program by revising the definition of a crime. The bill would enact other related provisions relative to budgeting, regional entities, federal preemption, subrogation, collective bargaining agreements, compensation of health care providers, conflict of interest, *patient grievances, independent medical review,* and associated matters.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Division 112 (commencing with Section 140000) is added to the Health and Safety Code, to read:

DIVISION 112. CALIFORNIA HEALTH INSURANCE RELIABILITY ACT

~~CHAPTER 1. GENERAL PROVISIONS~~

CHAPTER 1. GENERAL PROVISIONS

140000. There is hereby established in state government the California Health Insurance System, which shall be administered by the California Health Insurance Agency, an independent agency under the control of the Health Insurance Commissioner.

140000.5. The California Health Insurance Agency shall be a separate entity in state government and its decisions shall not be subject to review by any other agency, including, but not limited to, the Department of Finance, the Department of Personnel Administration, the Department of General Services, and the Office of Administrative Law, except as otherwise provided in Section 140307 with respect to that agency.

140001. This division shall be known as and may be cited as the California Health Insurance Reliability Act.

140002. This division shall be liberally construed to accomplish its purposes.

140003. The California Health Insurance Agency is hereby created and designated as the single state agency with full power to supervise every phase of the administration of the California Health Insurance System and to receive grants-in-aid made by

the United States government or by the state in order to secure full compliance with the applicable provisions of state and federal law.

140004. The California Health Insurance Agency shall be comprised of the following entities:

(a) The Health Insurance Policy Board.

(b) The Office of Consumer Advocacy.

(c) The Office of Health Care Planning.

(d) The Office of Health Care Quality.

(e) The Health Insurance Fund.

(f) The Public Advisory Committee.

(g) The Payments Board.

140005. The Legislature finds and declares all of the following:

~~(a) Six million three hundred thousand Californians lacked health insurance coverage at some time in 2003 and 3.5 million had no health insurance coverage at any time.~~

(a) Between six and seven million Californians lacked health insurance coverage at some time in 2004.

(b) Since 2001, the number of uninsured Californians has risen significantly.

(c) More than 10 million Californians have no coverage for prescription drugs. Millions of Californians lacking prescription drug coverage are otherwise insured.

(d) Efforts to control health care costs and growth of health care spending have been unsuccessful.

(e) Employers, retirement funds, and unions that offer and negotiate for health insurance and benefits and individuals who purchase health insurance are experiencing substantial increases in health care costs and decreases in health care benefits.

(f) Unstable and unaffordable rate increases have caused significant economic hardship for California residents and their employers.

(g) One in two personal bankruptcies in the United States is the result of health care costs.

(h) California does not perform well on *key* standard health outcome measurements.

(i) Severe health access disparities exist by region, ethnicity, income, and gender.

(j) Rural communities do not have reliable access to affordable health insurance plans.

(k) More than 80 percent of all Medi-Cal and uninsured patient visits to emergency facilities are for conditions that could have been treated in a nonemergency setting.

(*l*) Advances in medical technology are not available to all Californians who need them.

(m) Health care providers express significant professional dissatisfaction with the current health care systems, as do health care consumers.

(n) Uncompensated hospital care totaled over $1 billion in 2000. The burden for providing uncompensated care falls disproportionately on 12 percent of hospitals in California.

(o) Emergency departments and trauma centers face growing financial losses.

(p) Increasing patient volume and a decline in the number of emergency rooms have made multiple hour waits for emergency care the norm, and ambulance diversion is becoming a common method of dealing with emergency department overcrowding. These developments pose significant dangers for both insured and uninsured Californians.

(q) Multiple quantitative analysis including two recent studies by the independent economic consulting firm, Lewin Inc., indicate that under a single payer health insurance system, California could afford to cover all California residents at no new cost to the state while providing on average savings to California consumers, businesses, and state and local government.

(r) According to these reports and numerous other studies, by simplifying administration, achieving bulk purchase discounts on pharmaceuticals, and reducing the use of emergency facilities for primary care, California could divert billions of dollars toward providing direct health care and improved quality and access.

140005.1. (a) The Legislature also finds and declares that a relevant aspect of market competition in a health care system exists through the consumer choice of a direct care provider, and that the current health care system stifles this type of market competition in a way that is detrimental to overall health care quality and patient safety.

(b) It is the intent of the Legislature that, in order to ensure an adequate supply and distribution of direct care providers in the

state, a just and fair return for providers electing to be compensated by the health care system, and a uniform system of payments, the state shall actively supervise and regulate a system of payments whereby groups of competing fee-for-service physicians are authorized to select a representative to negotiate with the health care system, pursuant to Section 140209. Nothing in this division shall be construed to allow collective action against the health care system.

140006. This division shall have all of the following purposes:

(a) To provide universal and affordable health insurance coverage for all California residents.

(b) To provide California residents with an ~~extensive~~ *comprehensive* benefit package.

(c) To control health care costs and the growth of health care spending.

(d) To achieve measurable improvement in health care outcomes.

(e) To prevent disease and disability and to maintain or improve health and functionality.

(f) To increase health care provider, consumer, employee, and employer satisfaction with the health care system.

(g) To implement policies that strengthen and improve culturally and linguistically sensitive care.

(h) To develop an integrated population-based health care database to support health care planning.

140007. As used in this division, the following terms have the following meanings:

(a) "Agency" means the California Health Insurance Agency.

(b) "Clinic" means an organized outpatient health facility that provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and that may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility, and includes those facilities defined under Sections 1200 and 1200.1 of the Health and Safety Code.

(c) "Commissioner" means the Health Insurance Commissioner.

(d) "Direct care provider" means any licensed health care professional that provides health care services through direct

contact with the patient, either in person or using approved telemedicine modalities as identified in Section 2290.5 of the Business and Profession Code.

(e) "Essential community provider" means a health facility that has served as part of the state's health care safety net for low income and traditionally undeserved populations in California and that is one of the following:

(1) A "community clinic" as defined under subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(2) A "free clinic" as defined under subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(3) A "federally qualified health center" as defined under Section 1395x (aa)(4) or 1396d (*l*)(2) of Title 42 of the United States Code.

(4) A "rural health clinic" as defined under Section 1395x (aa)(2) or 1396d (*l*)(1) of Title 42 of the United States Code.

(5) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 of Title 25 of the United States Code.

(6) Any clinic exempt from licensure under subdivision (h) of Section 1206.

(f) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(g) "Health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, and includes those facilities defined under ~~suvdivision~~ *subdivision* (b) of Section 15432 of the Government Code.

(h) "Hospital" means all health facilities to which persons may be admitted for a 24-hour stay or longer, as defined in Section 1250 of the Health and Safety Code, with the exception of nursing, skilled nursing, intermediate care, and congregate living health facilities.

(i) "Integrated health care delivery system" means a provider organization that meets all of the following criteria:

(1) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

(2) Is compensated using capitation or facility budgets, except for copayments, for the provision of health care services.

(3) Provides health care services primarily ~~directly~~ through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or one or more groups of physicians, organized on a group practice or individual practice basis.

(j) "Large employer" means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar year employed at least 50 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least 50 employees on at least 50 percent of its working days during the preceding calendar quarter.

(k) "Primary care provider" means a direct care provider that is a family physician, internist, general practitioner, pediatrician, *osteopathic physician,* an obstetrician/gynecologist, or a family nurse practitioner or physician assistant practicing under supervision as defined in California codes or essential community providers who employ primary care providers.

(*l*) "Small employer" means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service and that, on at least 50 percent of its working days during the preceding calendar year employed at least two but no more than 49 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least two but no more than 40 eligible employees on at least 50 percent of its working days during the preceding calendar quarter.

(m) "System" or "health insurance system" means the California Health Insurance System.

140008. The definitions contained in Section 140007 shall govern the construction of this division, unless the context requires otherwise.

~~CHAPTER 2. GOVERNANCE~~

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140100. (a) Except as otherwise provided in this section and in Section 140109, the commissioner shall be elected by the people in the same time, place and manner as the Governor and shall serve a term of eight years. A person serving as commissioner may stand twice for election to the position and may serve a total of 16 years.

(b) The commissioner may not be a state legislator or a member of the United States Congress while holding the position of commissioner.

(c) The commissioner shall not have been employed in any capacity by a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the California Health Insurance System for a period of two years prior to election as commissioner.

(d) For two years after completing service in the California Health Insurance System, the commissioner may not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the California Health Insurance System.

(e) In the event of a vacancy, or inability of the commissioner to perform the duties of office for a period of more than 90 days, an acting commissioner shall be appointed by the Governor and confirmed by the Senate for the balance of the commissioner's term pursuant to the same process provided in Section 5 of Article V of the California Constitution.

(f) The commissioner is subject to impeachment pursuant to the same process provided in Section 18 of Article IV of the California Constitution.

(g) The compensation and benefits of the commissioner shall be determined pursuant to the same process as provided in Section 8 of Article III of the California Constitution.

(h) The commissioner shall be subject to Title 9 (commencing with Section 81000) of the Government Code.

140101. (a) The commissioner shall be the chief officer of the California Health Insurance Agency and shall administer all aspects of the agency.

(b) The commissioner shall be responsible for the performance of all duties, the exercise of all power and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the agency. The commissioner shall perform all duties imposed upon him or her by this division and other laws related to health care, and shall enforce the execution of those related to ~~health care~~ *the system*, and shall enforce the execution of those provisions and laws to promote their underlying aims and purposes. These broad powers shall include, but are not limited to, the power establish the California Health Insurance System budget and to set rates, to establish California Health Insurance System goals, standards and priorities, to hire and fire and fix the compensation of agency personnel, make allocations to the health ~~care~~ *planning* regions and promulgate generally binding regulations concerning any and all matters related to the implementation of this division and its purposes.

(c) The commissioner shall appoint the deputy health insurance commissioner, the director of the Health Insurance Fund, the consumer advocate, the chief medical officer, ~~chief enforcement officer~~ *purchasing director*, the director of planning, the director of the Partnerships for Health, the regional health planning directors, the chief enforcement counsel, and legal counsel in any action brought by or against the commissioner under or pursuant to any provision of any law under the commissioner's jurisdiction, or in which the commissioner joins or intervenes as to a matter within the commissioner's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the commissioner or before a person authorized by the commissioner.

(d) The personnel of the agency shall perform duties as assigned to them by the commissioner. The commissioner shall designate certain employees by the rule or order that are to take and subscribe to the constitutional oath within 15 days after their appointments, and to file that oath with the Secretary of State.

The commissioner shall also designate those employees that are to be subject to Title 9 (commencing with Section 81000) of the Government Code.

(e) The commissioner shall adopt a seal bearing the inscription: "Commissioner, California Health Insurance Agency, State of California." The seal shall be affixed to or imprinted on all orders and certificate issued by him or her and other instruments as he or she directs. All courts shall take notice of this seal.

(f) The administration of the agency shall be supported from the Health Insurance Fund created pursuant to Section 140200.

(g) The commissioner, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the agency, unless the commissioner finds that this availability or publication is contrary to law. No provision of this division authorizes the commissioner or any of the commissioners assistants, clerks or deputies to disclose any information withheld from public inspection except among themselves or when the necessary or appropriate in a proceeding or investigation under this division or to other federal or state regulatory agencies. No provision of this division either creates or derogate from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the commissioner or any of his or her assistants, clerks and deputies.

(h) It is unlawful to the commissioner or any of his or her assistants, clerks or deputies to use for personal benefit any information that is filed with or obtained by the commissioner and that is not then generally available to the public.

(i) The commissioner shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate; contribution of more than five hundred dollars ($500) to any one candidate in a calendar year or a contribution in excess of an aggregate of one thousand dollars ($1,000) in a calendar year for all political parties or organizations; and attempting to avoid compliance with this prohibition by making contributions through a spouse or other family member.

(j) The commissioner shall not participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she or a family or a business partner or colleague has a financial interest.

(k) The commissioner, in pursuit of his or her duties, shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(*l*) The Attorney General shall render to the commissioner opinions upon all questions of law, relating to the construction or interpretation of any law under the commissioner's jurisdiction or arising in the administration thereof, that may be submitted to the Attorney General by the commissioner and upon the commissioner's request shall act as the attorney for the commissioner in actions and proceedings brought by or against the commissioner or under or pursuant to any provision of any law under the commissioner's jurisdiction.

140102. The commissioner shall do all of the following:

(a) Oversee the establishment as part of the administration of the agency all of the following:

(1) The Health Insurance Policy Board, pursuant to Section 140103.

(2) The Office of Consumer Advocacy, pursuant to Section 140105.

(3) The Office of Health Care Planning, pursuant to Section 140602.

(4) The Office of Health Care Quality pursuant to Section 140605.

(5) The Health Insurance Fund, pursuant to Section 410200.

(6) The Payments Board, pursuant to Section 140208.

(7) The Public Advisory Committee pursuant to Section 140104.

(b) Determine California Health Insurance System goals, standards, guidelines, and priorities.

(c) Establish health care regions, pursuant to Section 140112.

(d) Ensure the delivery of, and equal access to, high quality care for the population.

(e) Establish evidence-based standards to guide delivery of care and ensure a smooth transition to ~~delivery of care~~ *clinical decisionmaking* under statewide standards.

(f) Implement policies to ensure that all Californians receive culturally and linguistically sensitive care, pursuant to Section 140604, and develop mechanisms and incentives to achieve this purpose and means to monitor the effectiveness of efforts to achieve this purpose.

(g) Develop methods to measure and monitor the quality of care provided to Californians and to make needed improvements.

(h) Develop methods to measure and monitor the performance of health care providers and to make needed improvements.

(i) Establish a capital management plan for the California Health Insurance System, including, but not limited to, a standardized process and format for the development and submission of regional operating and regional capital budget requests.

(j) Ensure the establishment of policies that support the public health.

(k) Establish and maintain appropriate statewide and regional health care databases.

(*l*) Establish a means to identify areas of medical practice where standards of care do not exist and establish priorities and a timetable for their development.

(m) Establish standards for mandatory reporting by health care providers and penalties for failure to report.

(n) [Reserved]

(o) Establish a comprehensive budget that ensures adequate funding to meet the health care needs of the population and the compensation for providers for care provided pursuant to this division.

(p) Establish standards and criteria for allocation of operating and capital funds from the Health Insurance Fund as described in Chapter 3 (commencing with Section 140200).

(q) Establish standards and criteria for development and submission of provider operating budget requests.

(r) Determine the level of funding *to* be allocated to each health care region.

(s) Annually assess projected revenues and expenditures ~~pursuant~~ to assure financial solvency of the system.

(t) Institute necessary cost controls pursuant to Section 140203 to assure financial solvency of the system.

(u) Develop separate formulae for budget allocations and review the formulae annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees and prices.

(v) Meet regularly with the chief medical officer, the consumer advocate, the director of planning, the director of the payments board, the director of the partnerships for health, the Technical Advisory Committee, regional planning directors and regional medical officers to review the impact of the agency and its policies on the health of the population and on satisfaction with the California Health Insurance System.

(w) Negotiate for or set rates, fees and prices involving any aspect of the California Health Insurance System and establish procedures thereto.

(x) Establish a capital management framework for the California Health Insurance System pursuant to Section 140216 to ensure that the needs for capital health care infrastructure are met, pursuant to the goals of the system.

(y) Ensure a smooth transition to California Health Insurance System oversight of capital health care planning.

(z) Establish an evidence-based formulary for all prescription drugs and durable and nondurable medical equipment for use by the California Health Insurance System.

(aa) Utilize the purchasing power of the state to negotiate price discounts for prescription drugs and durable and nondurable medical equipment for use by the California Health Insurance System.

(bb) Ensure that use of state purchasing power achieves the lowest possible prices for the California Health Insurance System.

(cc) Create incentives and guidelines for research needed to meet the goals of the system and disincentives for research that does not achieve California Health Insurance System goals.

(dd) Implement eligibility standards for the system.

(ee) Provide support during the transition for training and job placement for persons who are displaced from employment as a result of the initiation of the new California Health Insurance System.

(ff) Establish an enrollment system that ensures all eligible California residents, including those who travel frequently; those who have disabilities that limit their mobility, hearing, or vision; those who cannot read; and those who do not speak or write English are aware of their right to health care and are formally enrolled.

(gg) Oversee the establishment of the system for resolution of disputes pursuant to Sections 140608 and 140609.

(hh) Establish an electronic claims and payments system for the California Health Insurance System, to which all claims shall be filed and from which all payments shall be made, and implement, to the extent permitted by federal law, standardized claims and reporting methods.

(ii) Establish a system of secure electronic medical records that comply with state and federal privacy laws and that are compatible across the system.

(jj) Establish an electronic referral system that is accessible to providers and to patients.

(kk) Establish guidelines for mandatory reporting by health care providers.

(ll) Establish a Technology Advisory Committee to evaluate the cost and effectiveness of new medical technology ~~and~~, *including electronic medical technology, and to* make recommendations ~~for the~~ *about the financial and health impact of their* inclusion ~~of those technologies~~ in the benefit package.

(mm) [Reserved]

(nn) Ensure that consumers of health care have access to information needed to support choice of physician.

(oo) Collaborate with the boards that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely fashion and that consumers and providers of health care have access to information needed to support choice of facility.

(pp) Establish a Health Insurance System Internet Web site that provides information to the public about the California Health Insurance System that includes, but is not limited to, information that supports choice of provider and facilities, informs the public about state and regional health insurance policy board meetings and activities of the Partnerships for Health.

(qq) Procure funds, including loans, lease or purchase of insurance for the system, its employees and agents.

(rr) Collaborate with state and local authorities, including regional health directors, to plan for needed earthquake retrofits in a manner that does not disrupt patient care.

(ss) Establish a process for the system to receive the concerns, opinions, ideas, and recommendation of the public regarding all aspects of the system.

(tt) Annually report to the Legislature and the Governor, on or before October of each year and at other times pursuant to this division, on the performance of the California Health Insurance System, its fiscal condition and need for rate adjustments, consumer copayments or consumer deductible payments, recommendations for statutory changes, receipt of payments from the federal government, whether current year goals and priorities are met, future goals, and priorities, and major new technology or prescription drugs or other circumstances that may affect the cost of health care.

140103. (a)The commissioner shall establish a Health Insurance Policy Board and shall serve as the president of the board.

(b) The board shall do all of the following:

(1) Establish health insurance system goals and priorities, including research and capital investment priorities.

(2) Establish the scope of services to be provided to the population.

(3) Determine when an increase in health insurance premiums or when a change in the health insurance premium structure is needed.

(4) Establish guidelines for evaluating the performance of the health insurance system, health care regions, and health care providers.

(5) Establish guidelines for ensuring public input on health insurance system policy, standards, and goals.

(c) The board shall consist of the following members:

(1) The commissioner.

(2) The deputy commissioner.

(3) The Health Insurance Fund Director.

(4) The consumer advocate.

(5) The chief medical officer.

(6) The Director of Health Care Planning.
(7) The Director of the Partnerships for Health.
(8) The Director of the Payments Board.
(9) The state public health officer.
(10) Two representatives from health care regional planning boards.
(A) A regional representative shall serve a term of one year and terms shall be rotated in order to allow every region to be represented within a five-year period.
(B) A regional planning director shall appoint the regional representative to serve on the board.
(d) It is unlawful for the board members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the board and that is not then generally available to the public.
140104. (a) The commissioner shall establish a public advisory committee to advise the Health Insurance Policy Board on all matters of health insurance system policy.
(b) Members of the public advisory committee shall include all of the following:
(1) Four physicians all of whom shall be board certified in their field. The Senate Committee on Rules and the Governor shall each appoint one member. The Speaker of the Assembly shall appoint two of these members, both of whom shall be primary care providers.
(2) One registered nurse, to be appointed by the Governor.
(3) One licensed vocational nurse, to be appointed by the Senate Committee on Rules.
(4) One licensed allied health practitioner, to be appointed by the Speaker of the Assembly.
(5) One mental health care provider, to be appointed by the Senate Committee on Rules.
(6) One dentist, to be appointed by the Governor.
(7) One representative of private hospitals, to be appointed by the Senate Committee on Rules.
(8) One representative of public hospitals, to be appointed by the Governor.
(9) Four consumers of health care. The Governor shall appoint two of these members, one of whom shall be a member of the disability community. The Senate Committee on Rules shall

appoint a member who is 65 years of age or older. The Speaker of the Assembly shall appoint the fourth member.

(10) One representative of organized labor, to be appointed by the Speaker of the Assembly.

(11) One representative of essential community providers, to be appointed by the Senate Committee on Rules.

(12) One union member, to be appointed by the Senate Committee on Rules.

(13) One representative of small business, to be appointed by the Governor.

(14) One representative of large business, to be appointed by the Speaker of the Assembly.

(15) One pharmacist, to be appointed by the Speaker of the Assembly.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall make good faith efforts to assure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(d) Any member appointed by the Governor, the Senate Committee on Rules, or the Speaker of the Assembly shall serve for a four-year term. These members may be reappointed for succeeding four-year terms.

(e) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was selected or appointed. The commissioner shall notify the appropriate appointing authority of any expected vacancies on the board.

(f) Members of the advisory committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive___ dollars ($___) for each full day of attending meetings of the board. For purposes of this section, “full day of attending a meeting” means presence at, and participation in, not less than 75 percent of the total meeting time of the board during any particular 24-hour period.

(g) The advisory committee shall meet at least six times a year in a place convenient to the public. All meetings of the board

shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(h) Appointed committee members shall have worked in the field they represent on the committee for a period of at least two years prior to being appointed to the committee.

(i) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the committee and that is not generally available to the public.

140105. (a) (1) There is within the agency an Office of Consumer Advocacy to represent the interests of the consumers of health care. The goal of the office shall be to help residents of the state secure the health care services and benefits to which they are entitled under the laws administered by the agency and to advocate on behalf of and represent the interests of consumers in governance bodies created by this division and in other forums.

(2) The office shall be headed by a consumer advocate appointed by the commissioner.

(3) The consumer advocate shall establish an office in the City of Sacramento and other offices throughout the state that shall provide convenient access to residents.

(b) The consumer advocate shall do all the following:

(1) Administer all aspects of the office of the consumer advocate.

(2) Assure that services of the consumer advocate are available to all California residents.

(3) Serve on the Health Insurance Policy Board and participate in the regional Partnership for Health.

(4) Oversee the establishment and maintenance of the grievance process and independent medical review system pursuant to Sections 140608 and 140609.

(5) Participate in the grievance process and independent medical review system on behalf of consumers pursuant to Sections 140608 and 140609.

(6) Receive, evaluate and respond to consumer complaints about the health insurance system.

(7) Provide a means to receive recommendations from the public about ways to improve the health insurance system and hold public hearings at least once annually to receive recommendations from the public.

(8) Develop educational and informational guides for consumers describing their rights and responsibilities and informing them about effective ways exercise their rights to secure health care services and to participate in the health insurance system. The guides shall be easy to read and understand, available in English and other languages, including Braille and formats suitable for those with hearing limitations, and shall be made available to the public by the agency, including access on the agency's Internet Web site and through public outreach and educational programs and displayed in provider offices and health care facilities.

(9) Establish a toll-free number to receive complaints regarding the agency and its services. Those with hearing and speech limitations may use the California Relay Service's toll-free telephone numbers to contact the Office of Consumer Advocacy. The agency Internet Web site shall have complaint forms and instructions on their use.

(10) Report annually to the public, the commissioner, and the Legislature about the consumer perspective on the performance of the health insurance system, including recommendations for needed improvements.

(c) Nothing in this division shall prohibit a consumer or class of consumers or the consumer advocate from seeking relief through the judicial system.

(d) The consumer advocate in pursuit of his or her duties shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(e) It is unlawful for the consumer advocate or any of his or her assistants, clerks or deputies to use for personal benefit any information that is filed with or obtained by the agency and that is not then generally available to the public.

140106. (a) There is within the Office of the Attorney General an Office of the Inspector General for the California Health Insurance System. The Inspector General shall be appointed by the Governor and subject to Senate confirmation.

(b) The Inspector General shall have broad powers to investigate, audit, and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the system, the costs of which are reimbursed by the system.

(c) The Inspector General shall investigate allegations of misconduct on the part of an employee or appointee of the agency and on the part of any health care provider of services that are reimbursed by the system and shall report any findings of misconduct to the Attorney General.

(d) The Inspector General shall investigate patterns of medical practice that may indicate fraud and abuse related to over or under utilization or other inappropriate utilization of medical products and services.

(e) The Inspector General shall arrange for the collection and analysis of data needed to investigate the inappropriate utilization of these products and services.

(f) The Inspector General shall conduct additional reviews or investigations of financial and business records when requested by the Governor or by any Member of the Legislature and shall report findings of the review or investigation to the Governor and the Legislature.

(g) The Inspector General shall establish a telephone hotline for anonymous reporting of allegations of failure to make health insurance premium payments established by this division. The Inspector General shall investigate information provided to the hotline and shall report any findings of misconduct to the Attorney General.

(h) The Inspector General shall annually report recommendations for improvements to the system or the agency to the Governor and the Legislature.

140107. The provisions of the Insurance Fraud Prevention Act (Chapter 12 (commencing with Section 1871) of Part 2 of Division 1 of the Insurance Code), and the provisions of Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code, shall be applicable to health care providers who receive payments for services through the system under this division.

140108. (a) Nothing contained in this division is intended to repeal any legislation or regulation governing the professional

conduct of any person licensed by the State of California or any legislation governing the licensure of any facility licensed by the State of California.

(b) All federal legislation and regulations governing referral fees and fee-splitting, including, but not limited to, Sections 1320a-7b and 1395nn of Title 42 of the United States Code shall be applicable to all health care providers of services reimbursed under this division, whether or not the health care provider is paid with funds coming from the federal government.

(c) [Reserved]

140109. (a) A transition commissioner of health insurance shall be appointed by the Governor not less than 75 days following the operative date of this division, and shall be subject to confirmation by the Senate within 30 days of nomination. If the Senate does not take up the nomination within 30 days, the nominee shall be considered to have been confirmed and may take office, except that, if the Senate is not in session at the time the Governor appoints the transition commissioner of health insurance, the Senate shall take up the confirmation of the nominee at the commencement of the next legislative session.

(b) The transition commissioner of health insurance shall take office within 30 days of confirmation and shall serve until a commissioner of health insurance is elected at the next regularly scheduled election of the Governor. The transition commissioner of health insurance may stand for election for commissioner of health insurance for one term.

(c) Should the Senate, by a vote fail to confirm the nominee, the Governor shall appoint a new nominee, subject to the confirmation of the Senate.

(d) The transition commissioner shall not have been employed in any capacity by a for-profit insurance, pharmaceutical or medical equipment company that plans to sell products to the California Health Insurance System for a period of two years prior to appointment to his or her position.

(e) For two years after completing service in the California Health Insurance System, the transition commissioner may not receive payments of any kind from, or be employed in any capacity by or act as a paid consultant to, a for-profit insurance, pharmaceutical or medical equipment company that plans to sell products to the California Health Insurance System.

(f) The transition commissioner shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate; contribution of more than five hundred dollars to any one candidate in a calendar year or a contribution in excess of an aggregate of one thousand dollars ($1,000) in a calendar year for all political parties or organizations; and attempting to avoid compliance with this prohibition by making contributions through a spouse or other family member.

(g) The transition commissioner shall not participate ~~shall participate~~ in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she or a family or a business partner or colleague has a financial interest.

140110. (a) The health insurance system shall be operational no later than two years after the operative date of this division.

(b) The transition shall be funded from a loan from the General Fund and from private sources identified by the commissioner.

(c) The transition commissioner shall attempt to recover moneys held by California foundations created pursuant to Article 11 (commencing with Section 1399.70) of Chapter 2.2 of Division 2 that were created pursuant to conversions of health plans from nonprofit to for profit status. Moneys recovered from these sources shall be used to fund the transition to the new health insurance system and, to the extent possible, to provide insurance coverage during the transition to uninsured Californians.

(d) The transition commissioner shall assess health plans and insurers for care provided by the system in those cases in which a person’s health care coverage extends into the time period in which the new system is operative.

(e) The transition commissioner shall implement means to assist persons who are displaced from employment as a result of the initiation of the new health insurance system, including the period of time during which assistance shall be provided and possible sources of funds to support retraining and job

placement. That support shall be provided for a period of five years from the date that this division becomes operative.

140111. (a) The transition commissioner shall appoint a transition advisory group to assist with the transition to the system. The transition advisory group shall include, but not be limited to, the following members:

(1) The transition commissioner.

(2) The consumer advocate.

(3) The chief medical officer.

(4) The Director of Health Care Planning.

(5) The Director of the Health Insurance Fund.

(6) *The State Public Health Officer.*

(7) Experts in health care financing and health care administration.

~~(7)~~

(8) Direct care providers.

~~(8)~~

(9) Representatives of retirement boards.

~~(9)~~

(10) Employer and employee representatives.

~~(10)~~

(11) Hospital, essential community provider, and long-term care facility representatives.

~~(11)~~

(12) Representatives from state departments and regulatory bodies that shall or may relinquish some or all parts of their delivery of health service to the system.

~~(12)~~

(13) Representatives of counties.

~~(13)~~

(14) Consumers of health care.

(b) The transition advisory group shall advise the commissioner on all aspects of the implementation of this division.

(c) The transition advisory group shall make recommendations to the commissioner, the Governor, and the Legislature on how to integrate health care delivery services and responsibilities relating to the delivery of the services of the following departments and agencies into the system:

(1) The State Department of Health Services.

(2) The Department of Managed Health Care.
(3) The Department of Aging.
(4) The Department of Developmental Services.
(5) The Health and Welfare Data Center.
(6) The Department of Mental Health.
(7) The Department of Alcohol and Drugs.
(8) The Department of Rehabilitation.
(9) The Emergency Medical Services Authority.
(10) The Managed Risk Medical Insurance Board.
(11) The Office of Statewide Health Planning and Development.
(12) The Department of Insurance.

(d) The transition advisory group shall report its findings to the commissioner, the Governor, and the Legislature. The transition to the system shall not adversely affect publicly funded programs currently providing health care services.

140112. (a) The purpose of regionalization is to support local planning and decisionmaking.

(b) The commissioner or transition commissioner shall establish up to 10 health ~~insurance system~~ *planning* regions composed of geographically contiguous counties grouped on the basis of the following considerations:

(1) Patterns of utilization *of health care services*.
(2) Health care resources, including workforce resources.
(3) Health needs of the population, including public health needs.
(4) Geography.
(5) Population and demographic characteristics.

(c) The commissioner or transitional commissioner shall appoint a director for each region. Regional planning directors shall serve at the will of the commissioner and may serve up to two eight year terms to coincide with the terms of the commissioner.

(d) Each regional planning director shall appoint a regional medical officer.

(e) Compensation for health system officers and appointees who are exempt from the civil service shall be established by the California Citizens Commission in accordance with Section 8 of Article III of the California Constitution, and shall take into consideration regional differences in the cost of living.

(f) The regional planning director and the regional medical officer shall be subject to Title 9 (commencing with Section 81000) of the Government Code and shall comply with the qualifications for office described in ~~Section~~ *subdivisions (b), (c), and (d) of Section 140100 and subdivisions (i) and (j) of Section 140101*.

140113. (a) Regional planning directors shall administer the health ~~insurance~~ *planning* region ~~and perform regional health care planning pursuant to this division~~. The regional planning director shall be responsible for all duties, the exercise of all powers and jurisdiction, and the assumptions and discharge of all responsibilities vested by law in the regional agency. The regional planning director shall perform all duties imposed upon him or her by this division and by other laws related to health care, and shall enforce execution of those provisions and laws to promote their underlying aims and purposes.

(b) The regional planning director shall reside in the region in which he or she serves.

(c) The regional planning director shall do all of the following:

(1) Establish and administer a regional office of the state agency. Each regional office shall include, at minimum, an office of each of the following: Consumer ~~Advocacy~~ *Advocate*, Health Care Quality, Health Care Planning, and Partnerships for Health.

(2) Establish regional goals and priorities pursuant to standards, goals, priorities, and guidelines established by the commissioner.

(3) Assure that regional administrative costs meet standards established by the act.

(4) Seek innovative means to lower the costs of administration in the region.

(5) Plan for the delivery of, and equal access to, high quality and culturally and linguistically sensitive care that meets the needs of all regional residents pursuant to standards established by the commissioner.

(6) Seek innovative means to improve care quality.

(7) Appoint regional planning board members and serve as president of the board.

(8) Implement policies established by the commissioner to provide support to persons displaced from employment as a result of the initiation of the new system.

(9) Make needed revenue sharing arrangements so that regionalization in no way limits a patient's choice of provider.

(10) Implement procedures established by the commissioner for the resolution of disputes.

(11) Implement processes established by the commissioner to permit the public to share concerns, provide ideas, opinions, and recommendations regarding all aspects of the system policy.

(12) Report regularly to the public and, at intervals determined by the commissioner, and pursuant to this division, to the commissioner, on the status of the regional ~~health insurance~~ *planning* system, including evaluating access to care, quality of care delivered, and provider performance and recommending needed improvements.

(13) Identify and prioritize regional health care needs and goals, in collaboration with the regional medical officer, regional health care providers, the regional planning board, and regional director of partnerships for health.

(14) Identify and maintain an inventory of regional health care assets.

(15) Establish and maintain regional health care databases.

(16) In collaboration with the regional medical officer, enforce reporting requirements established by the California Health Insurance System.

(17) Convene meetings of regional health care providers to facilitate coordinated regional health care planning.

(18) Establish and implement a regional capital management plan pursuant to the capital management plan established by the commissioner for the system.

(19) Implement standards ~~and formats standards~~ and formats established by the commissioner for the development and submission of operating *and capital* budget requests.

(20) Support regional providers in developing operating and capital budget requests.

(21) Receive, evaluate, and prioritize provider operating and capital budget requests pursuant to standards and criteria established by the commissioner.

(22) Prepare a three-year regional budget request that meets the health care needs of the region pursuant to this division, for submission to the commissioner.

(23) Establish a comprehensive three-year regional ~~health insurance~~ *planning* budget using funds allocated to the region by the commissioner.

(24) Regularly assess projected revenues and expenditures to ensure fiscal solvency of the regional ~~health insurance~~ *planning* system.

140114. (a) The regional medical officers shall do all of the following:

(1) Administer all aspects of the regional office of health care quality.

(2) Serve as a member of the Regional ~~Health Insurance~~ *Planning* Board.

(3) Support the delivery of high quality care to all residents of the region pursuant to this division.

(4) Ensure a smooth transition to care delivery by regional providers under evidence-based standards that guide clinical decision making.

(5) Support the development and distribution of user-friendly software for use by providers in order to support the delivery of high quality care.

(6) In collaboration with the chief medical officer, evaluate evidence-based standards of care in use at the time the California Health Insurance System becomes operative.

(7) Assure the implementation of improvements needed so that all standards of care *are* used to guide clinical decision making in the system *to ensure the delivery of uniformly high standards of care to all residents*.

~~(8) Assure the delivery of uniformly high standards of care to all residents.~~

~~(9)~~

(8) In collaboration with the regional planning director, oversee a regional effort to assure the establishment of community-based networks of solo providers, small group practices, essential community providers and providers of auxiliary California Health Insurance System services that support providers in, and assure the delivery of, comprehensive, coordinated care to patients.

~~(10)~~

(9) Assure the evaluation and measurement of the quality of care delivered in the region, including assessment of the

performance of individual providers, pursuant to standards and methods established by the chief medical officer.

~~(11)~~

(10) Provide feedback to and support and supervision of medical providers needed to improve the quality of care they deliver.

~~(12)~~

(11) Assure the provision of information to assist consumers in evaluating the performance of health care providers.

~~(13)~~

(12) Identify areas of medical practice where standards have not been established and collaborate with the chief medical officer, to establish priorities in developing needed standards.

~~(14)~~

(13) Collaborate with regional public health officers to establish regional health policies that support the public health.

~~(15)~~

(14) Establish a regional program to monitor and decrease medical errors and their causes pursuant to standards and methods established by the chief medical officer.

~~(16)~~

(15) Support the development and implementation of innovative means to provide high quality care and assist providers in securing funds for innovative demonstration projects that seek to improve care quality.

~~(17)~~

(16) Establish means to assess the impact of health insurance system policies intended to assure the delivery of high quality care and evidence-based standards.

~~(18)~~

(17) Collaborate with the chief medical officer and the director of planning in the development and maintenance of regional health care databases.

~~(19)~~

(18) Ensure the enforcement of health insurance system reporting requirements.

~~(20)~~

(19) Support providers in developing regional budget requests.

~~(21)~~

(20) Collaborate with the regional planning director of the partnerships for health to develop patient education on appropriate utilization of health care services.

~~(22)~~

(21) Annually report to the public, the regional planning board and the chief medical officer on the status of regional health care programs, needed improvements and plans to implement and evaluate delivery of care improvements.

140115. (a) Each region shall have a regional health ~~insurance~~ *planning* board consisting of 13 members who shall be appointed by the regional planning director. Members shall serve eight-year terms that coincide with the term of the regional planning director and may be reappointed for a second term.

(b) Regional planning board members shall have resided for a minimum of two years in the region in which they serve prior to appointment to the board.

(c) Regional planning board members shall reside in the region they serve while on the board.

(d) The board shall consist of the following members:

(1) The regional planning director, the regional medical officer and the regional director of the Partnerships for Health and a public health officer from one of the regional counties.

(2) When there is more than one county in a region, the public health officer board position shall rotate among the public health county officers on a timetable to be established by each regional planning board.

(3) A representative from the office of consumer advocacy.

(4) One expert in health care financing.

(5) One expert in health care planning.

(6) Two members who are direct patient care providers in the region.

(7) One member who represents ancillary health care workers in the region.

(8) One member representing hospitals in the region.

(9) One member representing essential community providers in the region.

(10) One member representing the public.

(e) The regional planning director shall serve as chair of the board.

(f) The purpose of the regional planning boards is to advise and make recommendations to the regional planning director on all aspects of regional health policy.

(g) Meetings of the board shall be open to the public pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

140116. The following conflict of interest prohibitions shall apply to all appointees of the commissioner or transition commission, including, but not limited to, the consumer advocate, the health insurance fund director, the purchasing director, the planning director, the director of the health payments board, the chief medical officer, the director of partnerships for health, regional directors, and the inspector general:

(a) The appointee shall not have been employed in any capacity by a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the system for a period of two years prior to appointment.

(b) For two years after completing service in the system, the appointee may not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the system.

(c) The appointee shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate; contribution of more than five hundred dollars ($500) to any one candidate in a calendar year or a contribution in excess of an aggregate of one thousand dollars ($1,000) in a calendar year for all political parties or organizations; and attempting to avoid compliance with this prohibition by making contributions through a spouse or other family member.

(d) The appointee shall not participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she or a family or a business partner or colleague has a financial interest.

~~CHAPTER 3. FUNDING~~

CHAPTER 3. FUNDING

Article 1. General Provisions

140200. (a) In order to support the agency effectively in the administration of this division, there is hereby established in the State Treasury the Health Insurance Fund. The fund shall be administered by a director appointed by the commissioner.

(b) All moneys collected, received, and transferred pursuant to this division shall be transmitted to the State Treasury to be deposited to the credit of the Health Insurance Fund for the purpose of financing the California Health Insurance System.

(c) All claims for health care services rendered shall be made to the Health Insurance Fund through an electronic claims and payments system; however, alternative provisions shall be made for providers without electronic systems.

(d) All payments made for health care services shall be disbursed from the Health Insurance Fund through an electronic claims and payments system; however, alternative provisions shall be made for providers without electronic systems.

(e) The director of the fund shall serve on the Health Insurance Policy Board.

140201. (a) The Director of the Health Insurance Fund shall establish the following accounts within the Health Insurance Fund:

(1) A system account to provide for all annual state expenditures for health care.

(2) A reserve account.

(b) During the first five years of operation of the system, the director shall maintain a reserve account that equals, at minimum, ____ percent of the system's budget. After five years of the system's operation, the director, at the request of the commissioner, may reduce the minimum reserve requirement to ___ percent of the system's budget.

140203. (a) The Director of the Health Insurance Fund shall immediately notify the commissioner when regional or statewide revenue and expenditure trends indicate that expenditures appear to exceed revenues.

(b) If the commissioner determines that statewide revenue trends indicate the need for statewide cost control measures, the commissioner shall convene the Health Insurance Policy Board to discuss the need for cost control measures and shall immediately report to the public regarding the possible need for cost control measures.

(c) Cost control measures include any or all of the following:

(1) Changes in the health insurance system or health facility administration that improve efficiency.

(2) Changes in the delivery of health care services that improve efficiency and care quality.

(3) Postponement of introduction of new benefits or benefit improvements.

(4) Postponement of planned capital expenditures.

(5) Adjustment of health care provider budgets to correct for inappropriate utilization, deficiencies in care quality or fraud, ~~pursuant to Chapter ___ (commencing with Section ___) and Chapter ____ (commencing with Section ___).~~ *pursuant to subdivisions (a) to (f), inclusive, of Section 140106, paragraph (4) of subdivision (a) of Section 140204, subdivision (a) of Section 140213, and subdivisions (c) and (d) of Section 140606.*

(6) Limitations on the reimbursement of California Health Insurance System managers and upper level managers.

(7) Limitations on health provider reimbursement above a specified amount of aggregate billing for employers other than the California Health Insurance System administration, whose compensation is determined by the payment board and who are not subject to state civil service statutes.

(8) Limitations on aggregate reimbursements to manufacturers of pharmaceutical and durable and nondurable medical equipment.

(9) Deferred funding of the reserve account.

(10) Imposition of copayments or deductible payments. Any copayment or deductible payments imposed shall be subject to all of the following requirements:

(A) No copayment or deductible may be established when prohibited by federal law.

(B) All copayments and deductibles shall meet federal guidelines for copayments and deductible payments that may lawfully be imposed on persons with low income.

(C) The commissioner shall establish standards and procedures for waiving copayments or deductible payments and a waiver card which shall be issued to a patient or to a family to indicate the waiver. Copayment and deductible waivers shall be reviewed annually by the regional planning director.

(D) Waivers shall not affect the reimbursement of health care providers.

(E) Any copayments or deductible payments established pursuant to this section shall be transmitted to the Treasurer to be deposited to the credit of the Health Insurance Fund.

(F) No copayments shall be established for preventive care as determined by a patient's primary provider.

(G) Imposition of an eligibility waiting period if the commissioner determines that large numbers of people are emigrating to the state for the purpose of obtaining health care through the California Health Insurance System.

(d) Nothing in this division shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(e) Nothing in this division shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this division.

(f) Cost control measures implemented by the commissioner and the health insurance policy board shall remain in place in the state until the commissioner and the Health Insurance Policy Board determine that the cause of a revenue shortfall has been corrected.

(g) If the Health Insurance Policy Board determines that cost control measures described in subdivision (c) will not be sufficient to meet a revenue shortfall, the commissioner shall report to the Legislature and to the public on the causes of the shortfall and the reasons for the failure of cost controls and shall recommend measures to correct the shortfall, including an increase in health insurance system premium payments.

140204. (a) If the commissioner or a regional planning director determines that regional revenue and expenditure trends indicate a need for regional cost control measures, the regional planning director shall convene the regional planning board to discuss the possible need for cost control measures and to make a

recommendation about appropriate measures to control costs. These may include any of the following:

(1) Changes in health insurance system or health facility administration that improve efficiency.

(2) Changes in the delivery of health services that improve efficiency or care quality.

(3) Postponement of planned regional capital expenditures.

(4) Limitation on reimbursement of health care providers, upper level managers, or pharmaceutical or medical equipment manufacturers above a specified amount of aggregate billing.

(b) In the event a regional planning board is convened to implement cost control measures, the commissioner shall participate in the regional planning board meeting.

(c) The regional planning director, in consultation with the commissioner, shall determine if cost control measures are warranted and those measures that shall be implemented.

(d) Imposition of copayments or deductibles, postponement of new benefits or benefit improvements, deferred funding of the reserve account, establishment of eligibility waiting periods and increases in health insurance premium payments may occur on a statewide basis only and with the concurrence of the commissioner and the Health Insurance Policy Board.

(e) If a regional planning director and regional planning board are considering imposition of cost control measures, the regional planning director shall immediately report to the residents of the region regarding the possible need for cost control measures.

(f) Cost control measures shall remain in place in a region until the regional planning director and the commissioner determine that the cause of a revenue shortfall has been corrected.

140205. (a) If, on June 30 of any year, the Budget Act for the fiscal year beginning on July 1 has not been enacted, all moneys in the reserve account of the Health Insurance Fund shall be used to implement this division until funds are available through the Budget Act.

(b) Notwithstanding any other provision of law and without regard to fiscal year, if the annual budget is not enacted by June 30 of any fiscal year preceding the fiscal year to which the budget would apply and if the commissioner determines that

funds in the reserve account are depleted, the following shall occur:

(1) The Controller shall annually transfer from the General Fund, in the form of one or more loans, an amount not to exceed a cumulative total of _____dollars ($____) in any fiscal year, to the Health Insurance Fund for the purpose of making payments to health care providers and to persons and businesses under contract with the health insurance system or with health providers to provide services, medical equipment, and pharmaceuticals to the California Health Insurance System.

(2) Upon enactment of the Budget Act in any fiscal year to which paragraph (1) applies, the Controller shall transfer all expenditures and unexpected funds loaned to the Health Insurance Fund to the appropriate Budget Act item.

(3) The amount of any loan made pursuant to paragraph (1) for which moneys were expended from the Health Insurance Fund shall be repaid by debiting the appropriate Budget Act item in accordance with procedures prescribed by the Department of Finance.

140206. (a) The commissioner annually shall prepare a health insurance system budget that includes all expenditures, specifies a limit on total annual state expenditures, and establishes allocations for each health care region that shall cover a three-year period and that shall be disbursed on a quarterly basis.

(b) The commissioner shall limit the growth of spending on a statewide and on a regional basis, by reference to average growth in state domestic product across multiple years; population growth, actuarial demographics and other demographic indicators; differences in regional costs of living, advances in technology and their anticipated adoption into the benefit plan; improvements in efficiency of administration and care delivery, improvements in the quality of care and to projected future state domestic product growth rates.

(c) The commissioner shall project health insurance system revenues and expenditures for 3, 6, 9, and 12 years pursuant to parameters prescribed in ~~Section ___~~ *subdivision (f) of Section 140206*.

(d) The commissioner shall annually convene a Health Insurance System Revenue and Expenditure Conference to

discuss revenue and expenditure projections and future health insurance system policy directions and initiatives, including means to lower the cost of administration. Participants shall include regional health directors and medical officers, directors of the Health Insurance Fund and Payments Board, the consumer advocate, state and regional directors of the Partnerships for Health, and representatives of the health insurance system facility upper level managers.

(e) The California Health Insurance System budget shall include all of the following:

(1) Providers and managers budget.

(2) Capitated *operating* budgets.

(3) Noncapitated operating budgets.

(4) Capital investment budget.

(5) Purchasing budget.

(6) Research and innovation budget.

(7) Workforce training and development budget.

(8) Reserve account.

(9) System administration system.

(10) Regional budgets.

(f) In establishing budgets, the commissioner shall make adjustments based on all of the following:

(1) Costs of transition to the new system.

(2) Projections regarding the health services anticipated to be used by California residents.

(3) Differences in cost of living between the regions, including the overhead costs of maintaining medical practices.

(4) Health risk of enrollees.

(5) Scope of services provided.

(6) Innovative programs that improve care quality, administrative efficiency, and workplace safety.

(7) Unrecovered cost of providing care to persons who are not members of the California Health Insurance System. The commissioner shall seek to recover the costs of care provided to nonhealth insurance system members.

(8) Costs of workforce training and development.

(9) Costs of correcting health outcome disparities and the unmet needs of previously uninsured and underinsured enrollees.

(10) Relative usage of different health care providers.

(11) Needed improvements in access to care.

(12) Projected savings in administrative costs.

(13) Projected savings due to provision of primary and preventive care to the population, including savings from decreases in preventable emergency room visits and hospitalizations.

(14) Projected savings from improvements in care quality.

(15) Projected savings from decreases in medical errors.

(16) Projected savings from systemwide management of capital expenditures.

(17) Cost of incentives and bonuses to support the delivery of high quality care, including incentives and bonuses needed to recruit and retain an adequate supply of needed providers and managers and to attract providers to medically underserved areas.

(18) Costs of treating complex illnesses, including disease management programs.

(19) Cost of implementing standards of care, care coordination, electronic medical records, and other electronic initiatives.

(20) Costs of new technology.

(21) Technology research and development costs and costs related to health insurance system use of new technologies.

(g) Moneys in the Reserve Account shall not be considered as available revenues for the purposes of preparing the system budget.

140207. The commissioner shall annually establish the total funds to be allocated for provider and manager compensation pursuant to this section. In establishing the provider and manager budgets, the commissioner shall allot sufficient funds to assure that California can attract and retain those providers and managers needed to meet the health needs of the population. In establishing provider and manager budgets, the commissioner shall allocate funds for both salaries and benefits to be provided to health insurance system officers and upper level managers who are exempt from state civil service statutes.

140208. (a) The commissioner shall establish the Payments Board and shall appoint a director and members of the board.

(b) *The commissioner shall retain the authority to review, approve, reject, and modify all payment contracts and compensation plans established pursuant to this section.*

(c) The Payments Board shall be composed of experts in health care finance and insurance systems, a designated representative of the commissioner, a designated representative the Health Insurance Fund and a representative of the regional planning directors who shall serve a two-year term. The position of regional representative shall rotate among the directors of the regional planning boards.

~~(c) The purpose of the board is to establish and maintain a plan for the compensation of all of the following pursuant to the manager and provider budget established by the commissioner.~~

(d) The board shall establish and actively supervise a uniform payments system for providers and managers and shall maintain a compensation plan for all of the following providers and managers pursuant to the provider and manager budget established by the commissioner:

(1) Upper level managers *employed* in private health care facilities, including hospitals, integrated health care systems, group *and solo* medical practices, and essential community facilities.

(2) ~~Elected and appointed~~ *Appointed* California health insurance system managers and officers who are exempt from statutes governing civil service employment.

(3) Health care providers including physicians, osteopathic physicians, dentists, podiatrists, nurse practitioners, physician assistants, chiropractors, acupuncturists, psychologists, social workers, marriage, family and child counselors, and other professional health care providers who are required by law to be licensed to practice in California and who provide services pursuant to the act.

(4) Health care providers licensed and accredited to provide services in California may choose to be compensated for their services either by the California Health Insurance System or by a person to whom they provide services.

(5) Nothing in this division is intended to interfere with, change, or affect the terms of compensation established under contracts between unions and the health insurance system during negotiations for the labor cost component of health insurance system operating budget.

(6) Providers electing to be compensated by the California Health Insurance System shall enter into a contract with the health insurance system pursuant to provisions of this section.

(7) Providers electing to be compensated by persons to whom they provide services, instead of by the California Health Insurance System may establish charges for their services.

Providers may choose to be reimbursed either by a patient or by the health insurance system for services rendered to a patient. Providers may not be reimbursed by a patient and by the health insurance system for the same service.

~~(d)~~

(e) No health care service plan contract or health insurance policy, except the California State Insurance Plan, may be sold in California for services provided by the California State Health Insurance Plan.

~~(e)~~

(f) Health care providers licensed or accredited to provide services in California, who choose to be compensated by the health insurance system instead of by patients to whom they provide services, may choose how they wish to be compensated under this division, as fee-for-service providers or as salaried providers in health care systems that provide comprehensive, coordinated services.

~~(f)~~

(g) Notwithstanding provisions of the Business and Professions Code, nurse practitioners, physician assistants, and others who under California law must be supervised by a physician, an osteopathic physician, a dentist, or a podiatrist, may choose fee-for-service compensation while under lawfully required supervision. However, nothing in this section shall interfere with the right of a supervising provider to enter into a contractual arrangement that provides for salaried compensation for employees who must be supervised under the law by a physician, an osteopathic physician, a dentist, or a podiatrist.

~~(g)~~

(h) The compensation plan shall include all of the following:

(1) Actuarially sound payments *that include a just and fair return* for providers in the fee-for-service sector and for providers working in health systems where comprehensive and

coordinated services are provided, including the actuarial basis for ~~them~~ *the payment*.

(2) Payment schedules which shall be in effect for three years.

(3) Bonus and incentive payments, including, but not limited to, all the following:

(A) Bonus payments for providers and upper level managers who, in providing services and managing facilities, practices and integrated health systems, pursuant to this division, meet performance standards and outcome goals established by the California Health Insurance System.

(B) Incentive payments for providers and upper level managers who provide services to the California Health Insurance System in areas identified by the Office of Health Care Planning as medically underserved.

(C) Incentive payments required to achieve the ratio of generalist to specialist providers needed in order to meet the standards of care and service needs of the population.

(D) Incentive payments required to recruit and retain nurse practitioners and physician assistants in order to provide primary and preventive care to the population.

(E) No bonus or incentive payment may be made in excess of the total allocation for provider and manager incentive and bonus reimbursement established by the commissioner in the health insurance system budget.

(F) No incentive may adversely affect the care a patient receives or the care a health provider recommends.

~~(h)~~

(i) Providers shall be paid for all services provided pursuant to this division, including care provided to persons who are subsequently determined to be ineligible for the California Health Insurance System.

~~(i)~~

(j) Licensed providers who deliver services not covered under the California Health Insurance System may establish rates for, and charge patients for those services.

~~(j)~~

(k) Reimbursement to providers and managers may not exceed the amount allocated by the commissioner to provider and manager annual budgets.

140209. (a) Fee-for-service providers shall choose representatives to negotiate reimbursement rates with the Payments Board on their behalf.

(b) The Payments Board shall establish a uniform system of payments for all services provided pursuant to this division.

(c) Payment schedules shall be available to providers in printed and in electronic documents.

(d) Payment schedules shall be in effect for three years, at which time payment schedules may be renegotiated. Payment adjustments may be made at the discretion of the pay board to meet the goals of the health insurance system.

(e) In establishing a uniform system of payments the Payments Board shall collaborate with regional health directors and shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers in the region.

(f) Fee-for-service providers shall submit claims electronically to the Health Insurance Fund and shall be paid within ____ business days for claims filed in compliance with procedures established by the Health Insurance Fund. In the event that a properly filed claim for eligible services is not paid within ____ business days, the provider shall be paid interest on the claim at a rate of _____, compounded daily.

140210. (a) Compensation for providers and upper level managers employed by integrated health care systems, group medical practices and essential community providers that provide comprehensive, coordinated services shall be determined according to the following guidelines:

(b) Providers and upper level managers employed by systems that provide comprehensive, coordinated health care services shall be represented by their respective employers for the purposes of negotiating reimbursement with the Payments Board.

(c) In negotiating reimbursement with systems providing comprehensive, coordinated services, the Payments Board shall take into consideration the need for comprehensive systems to have flexibility in establishing provider and upper level manager reimbursement.

(d) Payment schedules shall be in effect for three years. However, payment adjustments may be made at the discretion of the payment board to meet the goals of the health insurance system

(e) The Payments Board shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers and upper level managers to the regions.

(f) The Payments Board shall establish a timetable for reimbursement negotiations. In the event that an agreement on reimbursement is not reached according to the timetable established by the Payments Board, the Payments Board shall establish reimbursement rates, which shall be binding.

(g) Reimbursement negotiations shall be conducted consistent with the state action doctrine of the antitrust laws.

140211. (a) The Payments Board shall annually report to the commissioner on the status of provider and upper level manager reimbursement, including satisfaction with reimbursement levels and the sufficiency of funds allocated by the commissioner for provider and upper level manager reimbursement. The Payments Board shall recommend needed adjustments in the allocation for provider payments.

(b) The Office of Health Care Quality shall annually report to the commissioner on the impact of the bonus payments in improving quality of care, health outcomes and management effectiveness. The Payments Board shall recommend needed adjustments in bonus allocations.

(c) The Office of Health Care Planning shall annually report to the commissioner on the impact of the incentive payments in recruiting health professionals and upper level managers to underserved areas, in establishing the needed ratio of generalist to specialist providers and in attracting and retaining nurse practitioners and physician assistants to the state and shall recommend needed adjustments.

140212. (a) The commissioner shall establish an allocation for each region to fund regional operating budgets for a period of three years. Allocations shall be disbursed to the regions on a quarterly basis.

(b) Integrated health care systems, essential community providers and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated operating budget or a system operating budget that covers all costs of providing health care services.

(c) Providers choosing to function on the basis of a capitated or system operating budget shall submit three year operating budget requests to the regional planning director, pursuant to standards and guidelines established by the commissioner.

(1) Providers may include in their operating budget requests reimbursement for ancillary health care or social services that were previously funded by money now received and disbursed by the Health Insurance Fund.

(2) No payment may be made from an operating or a capitated budget for a capital expense except as stipulated in Section 140216.

(d) Regional planning directors shall negotiate operating budgets with regional health care entities, which shall cover a period of three years.

(e) Operating and capitated budgets shall include health care workforce labor costs other than those described in ~~Sections~~ _____ *paragraphs (1), (2), and (3) of subdivision (d) of Section 140208*. Where unions represent employees working in systems functioning under operating or capitated budgets, unions shall represent those employees in negotiations with the regional planning director for the purpose of establishing their reimbursement.

140213. (a) Health systems and medical practices functioning under operating and capitated budgets shall immediately report any projected operating deficit to the regional planning director. The regional planning director shall determine whether projected deficits reflect appropriate increases in utilization, in which case the director shall make an adjustment to the operating budget. If the director determines that deficits are not justifiable, no adjustment shall be made.

(b) If a regional planning director determines that adjustments to operating budgets will cause a regional revenue shortfall and that cost control measures may be required, the regional planning director shall report the possible revenue shortfall to the commissioner and take actions required pursuant to Section 140203.

140214. No payment may be made from a health system operating budget or from a capitated budget to provide a shareholder dividend.

(a) The Inspector General shall monitor operating budgets to determine whether an unlawful payment has been made pursuant to this section.

(b) The commissioner shall establish and enforce penalties for violations of this section.

(c) Penalty payments collected for violations of this section shall be remitted to the Health Insurance Fund for use in the California Health Insurance System.

(d) Nothing in this section is intended to prohibit payment of shareholder dividends from non-California Health Insurance System sources.

140215. (a) Margins generated by a facility operating under a health system capitated budget or from an operating budget may be retained and used to meet the health care needs of the population.

(b) No margin may be retained if that margin was generated through inappropriate limitations on access to care or compromises in the quality of care or in any way that adversely affected or is likely to adversely affect the health of the persons receiving services from a facility, integrated health care system, group medical practice or essential community provider functioning under an operating or capitated budget.

(1) The chief medical officer shall evaluate the source of margin generation and report violations of this section to the commissioner.

(2) The commissioner shall establish and enforce penalties for violations of this section.

(3) Penalty payments collected pursuant to violations of section shall be remitted to the Health Insurance Fund for use in the California Health Insurance System.

(c) Facilities operating under health system capitated and operating budgets may raise and expend funds from sources other than the California Health Insurance System including, but not limited to, private or foundation donors and other non-California Health Insurance System sources for purposes related to the goals of this division and in accordance with provisions of this division.

140216. (a) During the transition the commissioner shall develop a Capital Management Plan which shall govern all capital investments and acquisitions undertaken in the California

Health Insurance System. The plan shall include a framework, standards, and guidelines for all of the following:

(1) Standards whereby the office of health care planning shall oversee, assist in the implementation of, and ensure that the provisions of the capital management plan are enforced.

(2) Assessment and prioritization of short- and long-term California Health Insurance System capital needs on statewide and regional bases.

(3) Assessment of capital *health care* assets and capital health care shortages on a regional and statewide basis.

(4) Development by the commissioner of a health insurance system capital budget that supports health insurance system goals, priorities and performance standards and meets the health needs of the population.

(5) Development, as part of the California Health Insurance System capital budget, of regional capital allocations that shall cover a period of three years.

(6) Exploration and evaluation of, and support for, noninvestment means to meet health care needs, including, but not limited to, improvements in administrative efficiency, care quality, and innovative service delivery, use, adaptation or refurbishment of existing land and property and identification of publicly owned land or property that may be available to the California Health Insurance System and that may meet a capital need.

(7) Development of capital inventories on a regional basis, including the condition, utilization capacity, maintenance plan and costs, deferred maintenance of existing capital inventory and excess capital capacity.

(8) A process whereby those intending to make capital investments or acquisitions shall prepare a business case for making the investment or acquisition, including the full life-cycle costs of the project or acquisition, an environmental impact report that meets existing state standards, and a demonstration of how the investment or acquisition meets the health needs of the population it is intended to serve. Acquisitions include the acquisition of land, operational property, or administrative office space.

(9) Standards and a process whereby the regional planning directors shall evaluate, accept, reject, or modify a business plan

for a capital investment or acquisition. Decisions of a regional planning director may be appealed through a dispute resolution process established by the commissioner.

(10) Standards for binding project contracts between the Health Insurance System and the party developing a capital project or making a capital acquisition that shall govern all terms and conditions of capital investments and acquisitions, including terms and conditions for Health Insurance System grants, loans, lines of credit, and lease purchase arrangements.

(11) A process and standards whereby the Health Insurance Fund shall negotiate terms and conditions of the California Health Insurance System leans, grants, lines of credit and lease purchase arrangements for capital investments and acquisitions. Terms and conditions negotiated by the Health Insurance Fund shall be included in project contracts.

(12) A plan for the commissioner and for the regional planning directors to issue requests for proposals and to oversee a process of competitive bidding for the development of capital projects that meet the needs of the California Health Insurance System.

(13) Responses to requests for proposals and competitive bids shall include a description of how a project meets the service needs of the region and addresses the environmental impact report and shall include the full life-cycle costs of a capital asset.

(14) Requests for proposals shall address how intellectual property will be handled and shall include conflict-of-interest guidelines.

(15) A process and standards for periodic revisions in the Capital Management Plan, including annual meetings in each region to discuss the plan and make recommendations for improvements in the plan.

(16) Standards for determining when a violation of these provisions shall be referred to the Attorney General for investigation and possible prosecution of the violation.

(b) No registered lobbyist shall participate in or in any way attempt to influence the request for proposals or competitive bid process.

(c) Development of performance standards and a process to monitor and measure performance of those making capital health care investments and acquisitions, including those making capital investments pursuant to a state competitive bidding process.

(d) A process for earned autonomy from state capital investment oversight for those who demonstrate the ability to manage capital investment and capital assets effectively in accordance with California Health Insurance System standards, and standards for loss of earned autonomy when capital management is ineffective.

(e) Terms and conditions of capital project oversight by the California Health Insurance System shall be based on the performance history of the project developer. Providers may earn autonomy from oversight if they demonstrate effective capital planning and project management, pursuant to the goals and guidelines established by the commissioner. Providers who do not demonstrate such proficiency shall remain subject to oversight by the regional planning director or shall lose autonomy from oversight.

(f) In general, no capital investment may be made from an operating budget. However, guidelines shall be established for the types and levels of small capital investments that may be undertaken from an operating budget without the approval of the regional planning director.

(g) Any capital investments required for compliance with federal, state, or local regulatory requirements or quality assurance standards shall be exempt from paragraph (2) of subdivision (c) of Section 140212.

140217. (a) Regional planning directors shall develop a regional capital development plan pursuant to the California Health Insurance System capital management plan established by the commissioner. In developing the regional capital development plan, the regional planning director shall do all of the following:

(1) Implement the standards and requirements of the capital management plan established by the commissioner.

(2) Develop and annually update a regional budget request that covers a period of three years.

(3) Assist regional providers to develop capital budget requests pursuant to the California Health Insurance System capital management plan established by the commissioner.

(4) Receive and evaluate capital budget requests from regional providers.

(5) Establish ranking criteria to assess competing demands for capital.

(6) Participate in planning for needed earthquake retrofits. However, the cost of mandatory earthquake retrofits of health care facilities shall not be the responsibility of the California Health Insurance System.

(7) Conduct ongoing project evaluation to assure that terms and conditions of project funding are met.

(b) Services provided as a result of capital investments or acquisitions that do not meet the terms of the regional capital development plan and the capital management plan developed by the commissioner shall not be reimbursed by the California Health Insurance System.

140218. (a) Assets financed by state grants, loans and lines of credit and lease purchase arrangements, shall be owned, operated and maintained by the recipient of the grant, loan, line of credit or lease purchase arrangements, according to terms established at the time of issuance of the grant, loan or line of credit, or lease purchase arrangement.

(b) Assets financed under long-term leases with the California Health Insurance System shall be transferred to public ownership at the end of the lease.

~~(c) Assets financed by private capital or donations are owned, operated and maintained by the borrower or donor recipient.~~

(c) When an asset, which was in whole or in part financed by the system, is to be sold or transferred by a party that received system financing for purchase, lease, or construction of the asset, an impartial estimate of the fair market value of the asset shall be undertaken. The system shall receive a share of the fair market value of the asset at the time of its sale or transfer that is in proportion to the system's original investment. The system may elect to postpone receipt of its share of the value of the asset if the commissioner determines that the postponement meets the needs of the system.

140219. The health regions must make financial information available to the public when the California Health Insurance System contribution to a capital project is greater than fifty million dollars ($50,000,000). Information shall include the purpose of the project or acquisition, its relation to California Health Insurance System goals, the project budget and the

timetable for completion, and performance standards and benchmarks.

140220. (a) The commissioner shall establish a budget for the purchase of prescription drugs and durable and nondurable medical equipment for the health insurance system.

(b) The commissioner shall use the purchasing power of the state to obtain the lowest possible prices for prescription drugs and durable and nondurable medical equipment.

(c) The commissioner shall make discounted prices available to all California residents, health care providers, prescription drug and medical equipment wholesalers and retailers of products approved for use in and included in the benefit package of the California Health Insurance System.

140221. (a) The commissioner shall establish a budget to support research and innovation that has been recommended by the chief medical officer, the director of planning, the consumer advocates, the Partnerships for Health, the Technical Advisory Committee, and others as required by the commissioner.

(b) The research and innovation budget shall support the goals and standards of the California Health Insurance System.

140222. (a) The commissioner shall establish a budget to support the training, development and continuing education of health care providers and the health care workforce needed to meet the health care needs of the population and the goals and standards of the health insurance system.

(b) For the first five years of the operation of the California Health Insurance System, ____ percent of the Workforce Development and Training Budget shall be expended for the retraining and job placement of persons who have been displaced from employment as a result of the transition to the new health insurance system.

(c) The commissioner shall establish guidelines for giving special consideration for employment to persons who have been displaced as a result of the transition to the new health insurance system.

140223. (a) The commissioner shall establish a Reserve Budget pursuant to this section. The Reserve Budget shall contain no less than _____ percent of the California Health Insurance System Budget.

(b) The Reserve Budget may be used only for purposes set forth in this division.

140224. (a) The commissioner shall establish a budget that covers all costs of administering the California Health Insurance System.

(b) Administrative costs on a systemwide basis shall be limited to~~_____~~ *10* percent of system costs within five years of completing the transition to the California Health Insurance System.

(c) Administrative costs on a systemwide basis shall be limited to~~_____~~ *5* percent of system costs within 10 years of completing the transition to the California Health Insurance System.

(d) The commissioner shall ensure that the percentage of the budget allocated to support system administration stays within the allowable limits and shall continually seek means to lower system administrative cost.

(e) The commissioner shall report to the public, the regional planning directors and others attending the annual Health Insurance System Revenue and Expenditures Conference pursuant to Section 140205 on the costs of administering the system and the regions and shall make recommendations for lowering administrative costs and receive recommendations for lowering administrative costs.

Article 2. Revenues.

140230. [Reserved]

Article 3. Governmental Payments

140240. (a) (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current federal payments to the state for health care be paid directly to the California Health Insurance System, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds.

(2) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution for health care services in California that shall not decrease in relation to the contribution to other

states as a result of the waivers, exemptions, agreements, or legislation.

(b) (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current state payments for health care shall be paid directly to the system, which shall then assume responsibility for all benefits and services previously paid for by state government with those funds.

(2) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the Legislature a contribution for health care services that shall not decrease in relation to state government expenditures for health care services in the year that this division was enacted, except that it may be corrected for change in state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

(c) The commissioner shall establish formulas for equitable contributions to the California Health Insurance System from all California counties and other local government agencies.

(d) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all county or other local government agency payments shall be paid directly to the California Health Insurance System.

140241. The system's responsibility for providing care shall be secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for these programs are not transferred to the Health Insurance Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the system.

140242. In order to minimize the administrative burden of maintaining eligibility records for programs transferred to the system, the commissioner shall strive to reach an agreement with federal, state, and local governments in which their contributions to the Health Insurance Fund shall be fixed to the rate of change of the state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

140243. If, and to the extent that, federal law and regulations allow the transfer of Medi-Cal funding to the system, the commissioner shall pay from the Health Insurance Fund all

premiums, deductible payments, and coinsurance for qualified Medicare beneficiaries who are receiving benefits pursuant to Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 of the Welfare and Institutions Code.

140244. In the event and to the extent that the commissioner obtains authorization to incorporate Medicare revenues into the Health Insurance Fund, Medicare Part B payments that previously were made by individuals or the commissioner shall be paid by the system for all individuals eligible for both the system and the Medicare program.

Article 4. Federal Preemption

140300. (a) The commissioner shall pursue all reasonable means to secure a repeal or a waiver of any provision of federal law that preempts any provision of this division.

(b) In the event that a repeal or a waiver of law or regulations cannot be secured, the commissioner shall exercise his or her powers to promulgate rules and regulations, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this division.

140301. (a) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan that, under federal law, preempts provisions of this division, shall first seek benefits under that contract or plan before receiving benefits from the system under this division.

(b) No benefits shall be denied under the system created by this division unless the employee has failed to take reasonable steps to secure like benefits from the contract or plan, if those benefits are available.

(c) Nothing in this section shall preclude a person from receiving benefits from the system under this division that are superior to benefits available to the person under an existing contract or plan.

(d) Nothing in this division is intended, nor shall this division be construed, to discourage recourse to contracts or plans that are protected by federal law.

(e) To the extent permitted by federal law, a health care provider shall first seek payment from the contract or plan,

before submitting bills to the California Health Insurance System.

Article 5. Subrogation

140302. (a) It is the intent of this division to establish a single public payer for all health care in the State of California. However, until such time as the role of all other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(b) As used in this article, collateral source includes all of the following:

(1) Insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance.

(2) Health care service plans and pension plans.

(3) Employers.

(4) Employee benefit contracts.

(5) Government benefit programs.

(6) A judgment for damages for personal injury.

(7) Any third party who is or may be liable to an individual for health care services or costs.

(c) "Collateral source" does not include either of the following:

(1) A contract or plan that is subject to federal preemption.

(2) Any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in subdivision (b) is not excluded from the obligations imposed by this article by virtue of a contract or relationship with a governmental unit, agency, or service.

(d) The commissioner shall attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in California into the California Health Insurance System.

140303. Whenever an individual receives health care services under the system and he or she is entitled to coverage,

reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care provider shall forward this information to the commissioner. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the commissioner.

140304. (a) The system shall seek reimbursement from the collateral source for services provided to the individual, and may institute appropriate action, including suit, to recover the reimbursement. Upon demand, the collateral source shall pay to the Health Insurance Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the system.

(b) In addition to any other right to recovery provided in this article, the commissioner shall have the same right to recover the reasonable value of benefits from a collateral source as provided to the Director of Health Services by Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, in the manner so provided.

140305. (a) If a collateral source is exempt from subrogation or the obligation to reimburse the system as provided in this article, the commissioner may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the system.

(b) To the extent permitted by federal law, contractual retiree health benefits provided by employers shall be subject to the same subrogation as other contracts, allowing the California Health Insurance System to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenues of the benefits directly to the California Health Insurance System.

140306. (a) Default, underpayment, or late payment of any tax or other obligation imposed by this division shall result in the remedies and penalties provided by law, except as provided in this section.

(b) Eligibility for benefits under Chapter 4 (commencing with Section 140400) shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by this chapter.

140307. The agency and the commissioner shall be exempt from the regulatory oversight and review procedures empowered to the Office of Administrative Law pursuant to Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code. Actions taken by the agency, including, but not limited to, the negotiating or setting of rates, fees, or prices, and the promulgation of any and all regulations, shall be exempt from any review by the Office of Administrative Law, except for Sections 11344.1, 11344.2, 11344.3, and 11344.6 of the Government Code, addressing the publication of regulations.

140308. The California Health Insurance Agency shall adopt regulations to implement the provisions of this division. The regulations may initially be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), but those emergency regulations shall be in effect only from the effective date of this division until the conclusion of the transition period.

Chapter 4. Eligibility

140400. All California residents shall be eligible for the California Health Insurance System. Residency shall be based upon physical presence in the state with the intent to reside. The commissioner shall establish standards and a simplified procedure to demonstrate proof of residency.

140401. The commissioner shall establish a procedure to enroll eligible residents and provide each eligible individual with identification that can be used by health care providers to determine eligibility for services.

140402. (a) It is the intent of the Legislature for the California Health Insurance System to provide health care coverage to California residents who are temporarily out of the state. The commissioner shall determine eligibility standards for residents temporarily out of state for longer than 90 days who

intend to return and reside in California and for nonresidents temporarily employed in California.

(b) Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions established by the commissioner. The commissioner may require that a resident be transported back to California when prolonged treatment of an emergency condition is necessary.

140403. Visitors to California shall be billed for all services received under the system. The commissioner may establish intergovernmental arrangements with other states and countries to provide reciprocal coverage for temporary visitors.

140404. All persons eligible for health benefits from California employers but who are working in another jurisdiction shall be eligible for health benefits under this division providing that they make payments equivalent to the payments they would be required to make if they were residing in California.

140405. Unmarried, unemancipated minors shall be deemed to have the residency of their parent or guardian. If a minor's parents are deceased and a legal guardian has not been appointed, or if a minor has been emancipated by court order, the minor may establish his or her own residency.

140406. (a) An individual shall be presumed to be eligible if he or she arrives at a health facility and is unconscious, comatose, or otherwise unable, because of his or her physical or mental condition, to document eligibility or to act in his or her own behalf, or if the patient is a minor, the patient shall be presumed to be eligible, and the health facility shall provide care as if the patient were eligible.

(b) Any individual shall be presumed to be eligible when brought to a health facility pursuant to any provision of Section 5150 of the Welfare and Institutions Code.

(c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds pursuant to any provision of Section 5150 of the Welfare and Institutions Code, providing for involuntary commitment, shall be presumed eligible.

(d) All health facilities subject to state and federal provisions governing emergency medical treatment shall continue to comply with those provisions.

Chapter 5. Benefits

140500. Any eligible individual may choose to receive services under the California Health Insurance System from any willing professional health care provider participating in the system. No health care provider may refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination contained in the Fair Employment and Housing Act beginning with Section 12940 of the Government Code.

140501. Covered benefits in this chapter shall include all medical care determined to be medically appropriate by the consumer's health care provider, but are subject to limitations set forth in Section 140503. Covered benefits include, but are not limited to, all of the following:

(a) Inpatient and outpatient health facility services.

(b) Inpatient and outpatient professional health care provider services by licensed health care professionals.

(c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(d) Durable medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and their repair.

(e) Rehabilitative care.

(f) Emergency transportation and necessary transportation for health care services for disabled and indigent persons.

(g) Language interpretation and translation for health care services, including sign language for those unable to speak, or hear, or who are language impaired, and Braille translation or other services for those with no or low vision.

(h) Child and adult immunizations and preventive care.

(i) Health education.

(j) Hospice care.

(k) Home health care.

(*l*) Prescription drugs that are listed on the system formulary. Nonformulary prescription drugs may be included where standards and criteria established by the commissioner are met.

(m) Mental and behavioral health care.

(n) Dental care.

(o) Podiatric care.

(p) Chiropractic care.
(q) Acupuncture.
(r) Blood and blood products.
(s) Emergency care services.
(t) Vision care.
(u) Adult day care.
(v) Case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting.
(w) Substance abuse treatment.
(x) Care of up to 100 days in a skilled nursing facility following hospitalization.
(y) Dialysis.
(z) Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization.

140502. The commissioner may expand benefits beyond the minimum benefits described in this chapter when expansion meets the intent of this division and when there are sufficient funds to cover the expansion.

140503. The following health care services shall be excluded from coverage by the system:
(a) Health care services determined to have no medical indication by the commissioner and the chief medical officer.
(b) Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care provider in the system.
(c) Private rooms in inpatient health facilities where appropriate nonprivate rooms are available, unless determined to be medically necessary by a qualified, licensed health care provider in the system.
(d) Services of a professional health care provider or facility that is not licensed or accredited by the state except for approved services provided to a California resident who is temporarily out of the state.

140504. (a) ~~The commissioner shall institute no deductible payments or copayments other than for specialist visits that are unreferred by the primary care provider pursuant to subdivision (g) of Section 140600 during the initial two years of the systems operation. The commissioner and the Health Insurance Policy Board shall review this policy annually, beginning in the third year of operation, and determine whether deductible payments or copayments should be established.~~

~~(b) Patients shall incur a copayment charge for unreferred specialist visits, the amount of which shall be established by the commissioner.~~

~~(c) If the commissioner establishes copayments consistent with subdivision (a), they shall be limited to two hundred fifty dollars ($250) per person per year and five hundred dollars ($500) per family per year. Copayments for unreferred specialist visits shall not be subject to this limit.~~

~~(d) If the commissioner establishes deductible payments consistent with subdivision (a), they shall be limited to two hundred fifty dollars ($250) per person per year and five hundred dollars ($500) per family per year.~~

~~(e)~~ No copayments or deductible payments may be established for preventive care as determined by a patient's primary care provider.

~~(f)~~

(b) No copayments or deductible payments may be established when prohibited by federal law.

~~(g)~~

(c) The commissioner shall establish standards and procedures for waiving copayments or deductible payments. Waivers of copayments or deductible payments shall not affect the reimbursement of health care providers.

~~(h)~~

(d) Any copayments established pursuant to this section and collected by health care providers shall be transmitted to the Treasurer to be deposited to the credit of the Health Insurance Fund.

~~(i)~~

(e) Nothing in this division shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

~~(j)~~

(f) Nothing in this division shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this division.

Chapter 6. Delivery of Care

140600. (a) All health care providers licensed or accredited to practice in California may participate in the California Health Insurance System.

(b) No health care provider whose license or accreditation is suspended or revoked may be a participating health care provider.

(c) (1) [Reserved]

(2) If a health care provider is on probation, the licensing or the accrediting agency shall monitor the health care provider in question, pursuant to applicable California law. The licensing or accrediting agency shall report to the Chief Medical Officer at intervals established by the Chief Medical Officer, on the status of providers who are on probation, on measures undertaken to assist providers to return to practice and to resolve complaints made by patients.

(d) Health care providers may accept eligible persons for care according to the provider's ability to provide services needed by the applicant and according to the number of patients a provider can treat without compromising safety and care quality. A provider may accept patients in the order of time of application.

(e) A health care provider shall not refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination contained in the Fair Employment and Housing Act (Part 2.8 (commencing with Sec. 129000) of Division 3 of Title 2 of the Government Code).

(f) Choice of provider:

(1) Persons eligible for health care services under this division may choose a primary care provider.

(A) Primary care providers include family practitioners, general practitioners, internists and pediatricians, nurse practitioners and physician assistants practicing under

supervision as defined in California codes and Doctors of Osteopathy licensed to practice as general doctors.

(B) Women may choose an obstetrician-gynecologist, in addition to a primary provider.

(2) Persons who choose to enroll with integrated health care systems, group medical practices or essential community providers that offer comprehensive services, shall retain membership for at least one year after an initial three month evaluation period during which time they may withdraw for any reason.

(A) The three-month period shall commence on the date when an enrollee first sees a primary provider.

(B) Persons who want to withdraw after the initial three-month period shall request a withdrawal pursuant to dispute resolution procedures established by the commissioner and may request assistance from the consumer advocate in the dispute process. The dispute shall be resolved in a timely fashion and shall have no adverse effect on the care a patient receives.

(3) Persons needing to change primary providers because of health care needs that their primary provider cannot meet may change primary providers at any time.

140601. (a) Primary care providers shall coordinate the care a patient receives or shall ensure that a patient's care is coordinated.

(b) (1) Patients shall have a referral from their primary care provider, or from an emergency provider rendering care to them in the emergency room or other accredited emergency setting, or from a provider treating a patient for an emergency condition in any setting, or from their obstetrician/gynecologist, to see a physician or nonphysician specialist whose services are covered by this division, unless the patient agrees to assume the costs of care, in which case a referral is not needed. A referral shall not be required to see a dentist.

(2) Referrals shall be based on the medical needs of the patient and on guidelines which shall be established by the chief medical officer to support clinical decisionmaking.

(3) Referrals shall not be restricted or provided solely because of financial considerations. The chief medical officer shall monitor referral patterns and intervene as necessary to assure that

referrals are neither restricted nor provided solely because of financial considerations.

~~(4) Patients established with a specialist before the system is implemented do not need a referral to continue seeing the specialist or their designee.~~

(4) For the first six months of system operation, no specialist referral shall be required for patients who had been receiving care from a specialist prior to the initiation of the system. Beginning with the seventh month of system operation, all patients shall be required to obtain a referral from a primary or emergency care provider for specialty care if the care is to be paid for by the system. No referral is required if a patient pays the full cost of the specialty care and the specialist accepts that payment arrangement.

(5) Where referral systems are in place prior to the initiation of the system, the chief medical officer shall review the referral systems to assure that they meet health insurance system standards for care quality and shall assure needed changes are implemented so that all Californians receive the same standards of care quality.

(6) A specialist may serve as the primary provider if the patient and the provider agree to this arrangement and if the provider agrees to coordinate the patient's care or to ensure that the care the patient receives is coordinated.

(7) The commissioner shall establish or ensure the establishment of a computerized referral registry to facilitate the referral process and to allow a specialist and a patient to easily determine whether a referral has been made pursuant to this division.

(8) A patient may appeal the denial of a referral through the dispute resolution procedures established by the commissioner and may request the assistance of the consumer advocate during the dispute resolution process.

140602. (a) The purpose of the Office of Health Care Planning is to plan for the short and long term health needs of the population pursuant to the health care and finance standards established by the commissioner and by this division.

(b) The office shall be headed by a planning director appointed by the commissioner. The director shall serve pursuant to

provisions of ~~Section _____~~ *subdivisions (b), (c), and (d) of Section 140100 and subdivisions (i) and (j) of Section 140101*.

(c) The director shall do all the following:

(1) Administer all aspects of the Office of Health Care Planning.

(2) Serve on the Health Insurance Policy Board.

(3) Establish performance criteria in measurable terms for health care goals in consultation with the chief medical officer, the regional health officers and directors and others with experience in health care outcomes measurement and evaluation.

(4) Evaluate the ~~performance criteria~~ *effectiveness of performance criteria in accurately measuring quality of care, administration, and planning*.

(5) Assist the health care regions to develop operating and capital requests pursuant to health care and finance guidelines established by the commissioner and by this division. In assisting regions, the director shall do all of the following:

(A) Identify medically undeserved areas and health service shortages.

(B) Identify disparities in health outcomes.

(C) Support establishment of comprehensive health care databases using uniform methodology that is compatible between the regions and between the regions and the state health insurance agency.

(D) Provide information to support effective regional planning.

(E) Provide information to support interregional planning, including planning for access to specialized centers that perform a high volume of procedures for conditions requiring highly specialized treatments, including emergency and trauma and other interregional access to needed care, and planning for coordinated interregional capital investment.

(F) Provide information for, and participate in, earthquake retrofit planning.

(G) Evaluate regional budget requests and make recommendations to the commissioner about regional revenue allocations.

(1) Estimate the health care workforce required to meet the health needs of the population pursuant to the standards and goals established by the commissioner, the costs of providing the

needed workforce, and, in collaboration with regional planners, educational institutions, the Governor and the Legislature, develop short and long term plans to meet those needs, including a plan to finance needed training.

(2) Estimate the number and types of health facilities required to meet the short and long term health needs of the population and the projected costs of needed facilities. In collaboration with the commissioner, regional planning directors and health officers, the chief medical officer, the Governor and the Legislature, develop plans to finance and build needed facilities.

140603. The ~~Director of the Office of Health Care Planning shall establish~~ *Technical Advisory Group shall explore the feasibility and the value to the health of the population of* the following electronic initiatives:

(a) Establish integrated statewide health care databases to support health care planning and determine which databases which should be established on a statewide basis and which should be established on a regional basis.

(b) Assure that databases have uniform methodology and formats that are compatible between regions and between the regions and the state insurance agency.

(c) Establish mandatory database reporting requirements and penalties for noncompliance. Monitor the effectiveness of reporting and make needed improvements.

(d) Establish electronic, online, scheduling systems for use in the health insurance system.

(e) Establish electronic provider patient communication systems that allow for e-visits, for use in the health insurance system.

(f) Establish electronic systems that allow standard of care guidelines, including disease management programs to be embedded in a patient's electronic medical records.

(g) Establish electronic systems that give information to providers about community-based patient care resources.

(h) *Establish electronic initiatives that improve quality of care and the efficiency of care delivery.*

(i) Establish electronic initiatives that lower administration costs.

(j) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems

that link clinical guidelines to individual patient conditions, and guide clinicians through diagnosis and treatment algorithms based on evidence-based research and best medical practices.

~~(i)~~

(k) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that offer providers access to guidelines that are appropriate for their specialty and that include current information on prevention and treatment of disease.

~~(j)~~

(l) In collaboration with the Partnerships for Health and regional health officers, establish Web-based patient-centered information systems that assist people to promote *and maintain* health and provide information on health conditions and recent developments in treatment.

~~(k)~~

(m) Establish electronic systems and other means to provide patients with easily understandable information about the performance of health care providers. This shall include, but not be limited to, information about the experience that providers have in the field or fields in which they deliver care, the number of years they have practiced in their field and, in the case of medical and surgical procedures, the number of procedures they have performed in their area or areas of specialization.

~~(l)~~

(n) Establish electronic systems that facilitate provider continuing medical education that meets licensure requirements.

~~(m)~~

(o) Establish means for anonymous reporting of suspected medical errors.

~~(n)~~

(p) Recommend to the commissioner means to link health care research with the goals and priorities of the health insurance system.

140604. (a) The Director of the Office of Health Care Planning shall establish standards for culturally and linguistically competent care, which shall include, but not be limited to, all of the following:

(1) State Department of Health Services and the Department of Managed Care guidelines for culturally and linguistically sensitive care.

(2) Medi-Cal Managed Care Division (MMCD) Policy Letters 99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural and Linguistic.

(3) Subchapter 5 of the Civil Rights Act of 1964 (42 U.S.C. Sec. 2000d).

(4) United States Department of Health and Human Services' Office of Civil Rights; Title VI of the Civil Rights Act of 1964; Policy Guidance on Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency (February 1, 2002).

(5) United States Department of Health and Human Services' Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care—Final Report (December 22, 2000).

(b) The director shall annually evaluate the effectiveness of standards for culturally and linguistically competent care and make recommendations to the commissioner, the consumer advocate and the chief medical officer for needed improvements.

(c) The director shall pursue available federal financial participation for the provision of a language services program that supports health insurance system goals.

140605. (a) Within the agency, the commissioner shall establish the Office of Health Care Quality.

(b) The office shall be headed by the chief medical officer who shall serve pursuant to provisions of ~~Section _____~~ *subdivisions (b), (c), and (d) of Section 140100 and subdivisions (i) and (j) of Section 140101* regarding qualifications for appointed health insurance system officers.

(c) The purpose of the Office of Health Care Quality is the following:

(1) Support the delivery of high quality, coordinated health care services that enhance health, prevent illness, disease and disability, slow the progression of chronic diseases and improve personal health management.

(2) Promote efficient care delivery.

(3) Establish processes for measuring, monitoring and evaluating the quality of care delivered in the health insurance system, including the performance of individual providers.

(4) Establish means to make changes needed to improve care quality, including innovative programs that improve quality.

(5) Promote patient, provider and employer satisfaction with the health insurance system.

(6) Assist regional planning directors and medical officers in the development and evaluation of regional budget requests.

140606. (a) In supporting the goals of the Office of Health Care Quality, the chief medical officer shall do all of the following:

(1) Administer all aspects of the office.

(2) Serve on the Health Insurance Policy Board.

(3) Collaborate with regional medical officers, directors, health care providers, and consumers, the director of planning, the consumer advocate and Partnership for Health directors to develop community-based networks of solo providers, small group practices, essential community providers and providers of patient care support services in order to offer comprehensive, multidisciplinary, coordinated services to patients.

(4) Establish evidence-based standards of care for the health insurance system which shall serve as guidelines to support providers in the delivery of high quality care. Standards shall be based on the best evidence available at the time and shall be continually updated. Standards are intended to support the clinical judgment of individual providers, not to replace it and to support clinical decisions based on the needs of individual patients.

(b) In establishing standards, the chief medical officer shall do all of the following:

(1) Draw on existing standards established by California health care institutions, on peer-created standards, and on standards developed by others institutions that have had a positive impact on care quality, such as the Centers for Disease Control and the Agency for Health Care Quality and Research.

(2) Collaborate with regional medical officers in establishing regional goals, priorities and a timetable for implementation of standards of care.

(3) Assure a process for patients to provide their views on standards of care to the consumer advocate who shall report those views to the chief medical officer.

(4) Collaborate with the director of planning and regional medical officers to support the development of computer software systems that link clinical guidelines to individual patient conditions, guide clinicians through diagnosis and treatment algorithms based on evidence-based research and best medical practices, offer access to guidelines appropriate to each medical specialty and offer current information on disease prevention and treatment and that support continuing medical education.

(5) Where referral systems for access to specialty care are in place prior to the initiation of the health insurance system, the chief medical officer shall review the referral systems to assure that they meet health insurance system standards for care quality and shall assure that needed changes are implemented so that all Californians receive the same standards of care quality.

(c) In collaboration with the director of planning and regional medical officer, the chief medical officer shall implement means to measure and monitor the quality of care delivered in the health insurance system. Monitoring systems shall include, but shall not be limited to, peer and patient performance reviews.

(d) The chief medical officer shall establish means to support individual providers and health systems in correcting quality of care problems, including timeframes for making needed improvements and means to evaluate the effectiveness of interventions.

(e) In collaboration with regional medical officers and directors and the director of planning, the chief medical officer shall establish means to identify medical errors and their causes and develop plans to prevent them.

(f) The chief medical officer shall convene an annual statewide conference to discuss medical errors that occurred during the year, their causes, means to prevent errors, and the effectiveness of efforts to decrease errors.

(g) The chief medical officer shall recommend to the commissioner an evidence-based benefits package for the health insurance system, including priorities for needed benefit improvements. In making recommendations, the chief medical officer shall do all of the following:

(1) Identify safe and effective treatments.

(2) Evaluate and draw on existing benefit packages.

(3) Receive comments and recommendations from health care providers about benefits that meet the needs of their patients.

(4) Receive comments and recommendations made directly by patients or indirectly through the consumer advocate.

(5) Identify and recommend to the commissioner and the Health Insurance Policy Board innovative approaches to health promotion, disease and injury prevention, education, research and care delivery for possible inclusion in the benefit package.

(6) Identify complementary and alternative modalities that have been shown by the National Institutes of Health, Division of Complementary and Alternative Medicine to be safe and effective for possible inclusion as covered benefits.

(7) Recommend to the commissioner and update as appropriate, an evidence-based pharmaceutical and durable and nondurable medical equipment formularies. In establishing the formularies the chief medical officer shall establish a Pharmacy and Therapeutics Committee composed of pharmacy and medical health care providers, representatives of health facilities and organizations have system formularies in place at the time the system is implemented and other experts that shall do all the following:

(8) Identify safe and effective pharmaceutical agents for use in the California Health Insurance System.

(9) Draw on existing standards and formularies.

(10) Identify experimental drugs and drug treatment protocols for possible inclusion in the formulary.

(11) Review formularies in a timely fashion to ensure that safe and effective drugs are available and that unsafe drugs are removed from use.

(12) Assure the timely dissemination of information needed to prescribe safely and effectively to all California providers.

(13) Establish standards and criteria and a process for providers to seek authorization for prescribing pharmaceutical agents and durable and nondurable medical equipment that are not included in the system formulary. No standard or criteria shall impose an undue administrative burden on patients, health care providers, including pharmacies and pharmacists, and none shall delay care a patient needs.

(14) Develop standards and criteria and a process for providers to request authorization for services and treatments, including experimental treatments that are not included in the system benefit package.

(A) Where such processes are in place when the health insurance system is initiated, the chief medical officer shall review the systems to assure that they meet health insurance system standards for care quality and shall assure that needed changes are implemented so that all Californians receive the same standards of care quality.

(B) No standard or criteria shall impose an undue administrative burden on a provider or a patient and none shall delay the care a patient needs.

(15) In collaboration with the director of planning, regional planning directors and regional medical officers, identify appropriate ratios of general medical providers to specialty medical providers on a regional basis ~~that~~ *in order to* meet the health care needs of the population and the goals of the health insurance system.

(16) Recommend to the commissioner and to the Payment Board, financial and non-financial incentives and other means to achieve recommended provider ratios.

(17) Collaborate with the director of planning and regional medical officers and consumer advocates in development of electronic initiatives, pursuant to Section 140603.

(18) Collaborate with the commissioner, the regional health officers, the directors of the Payments Board and the Health Insurance Fund to formulate a provider reimbursement model that promotes the delivery of coordinated, high quality health services in all sectors of the health insurance system and creates financial and other incentives for the delivery of high quality care.

(19) Establish or assure the establishment of continuing medical education programs about advances in the delivery of high quality of care.

(20) Convene an annual statewide quality of care conference to discuss problems with care quality and to make recommendations for changes needed to improve care quality. Participants shall include regional medical directors, health care

providers, providers, patients, policy experts, experts in quality of care measurement and others.

(21) Annually report to the commissioner, the Health Insurance Policy Board and the public on the quality of care delivered in the health insurance system, including improvements that have been made and problems that have been identified during the year, goals for care improvement in the coming year and plans to meet these goals.

(h) No person working within the agency, or on a pharmacy and therapeutics committee or serving as a consultant to the agency or a pharmacy and therapeutics committee, may receive fees or remuneration of any kind from a pharmaceutical company.

140607. (a) The consumer advocate, in collaboration with the chief medical officer, the regional consumer advocates, medical officers, and directors, shall establish a program in the state health insurance agency and in each region called the "Partnerships for Health".

(b) The purpose of the Partnerships for Health is to improve health through community health initiatives, to support the development of innovative means to improve care quality, to promote efficient*, coordinated* care delivery, and to educate of the public about the following:

(1) Personal maintenance of health.

(2) Prevention of disease.

(3) Improvement in communication between patients and providers.

(4) Improving quality of care.

(c) The consumer *advocate* shall work with the community and health care providers in proposing Partnerships for Health projects and in developing project budget requests that shall be included in the regional budget request to the commissioner.

(d) In developing educational programs, the Partnerships for Health shall collaborate with educators in the region.

(e) Partnerships for Health shall support the coordination of California Health Insurance System and public health system programs.

~~140608. (a) The consumer advocate shall do all of the following:~~

~~(1) Establish and maintain a grievance system approved by the health care commissioner under which enrollees may submit their grievances to the system. The system shall provide reasonable procedures in accordance with state regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.~~

~~(2) Inform enrollees upon enrollment in the system and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.~~

~~(3) Provide printed and electronic access for enrollees who wish to register grievances. The forms used by the system shall be approved by the commissioner in advance as to format.~~

~~(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:~~

~~(i) That the grievance has been received.~~

~~(ii) The date of receipt.~~

~~(iii) The name of the system representative and the telephone number and address of the system representative who may be contacted about the grievance.~~

~~(B) Grievances received by telephone, by facsimile, by e-mail, or online through the system's Web site that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The consumer advocate shall maintain a log of all these grievances. The log shall be periodically reviewed by the consumer advocate and shall include the following information for each complaint:~~

~~(i) The date of the call.~~

~~(ii) The name of the complainant.~~

~~(iii) The complainant's system identification number.~~

~~(iv) The nature of the grievance.~~

~~(v) The nature of the resolution.~~

~~(vi) The name of the system representative who took the call and resolved the grievance.~~

~~(5) Provide enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the system's response. For grievances involving the delay, denial, or modification of health care services, the system response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the system, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services to an enrollee based in whole or in part on a finding that the proposed health care services are not a covered benefit in the system that applies to the enrollee, the decision shall clearly specify the system provisions that exclude that coverage.~~

~~(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.~~

~~(7) Establish and maintain a Web site that shall provide an online form that enrollees can use to file with a grievance, as described in paragraph (3) of subdivision (b), online.~~

~~(b) (1) The commissioner may require enrollees and subscribers to participate in a plan's grievance process for up to 30 days before pursuing a grievance through the commissioner or the independent medical review system. However, the commissioner may not impose this waiting period for expedited review cases covered by subdivision (b) of Section 1368.01 or in any other case where the commissioner determines that an earlier review is warranted.~~

~~(2) In any case determined by the consumer advocate to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the consumer advocate determines that an earlier review is warranted, an enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the independent medical review system established pursuant to Section 140609.~~

~~(3) Notwithstanding subparagraphs (1) and (2), the consumer advocate may refer any grievance that does not pertain to compliance with this act to the federal Health Care Financing Administration, or any other appropriate local, state, and federal governmental entity for investigation and resolution.~~

~~(4) If the enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the enrollee, as appropriate, may submit the grievance to the consumer advocate as a designated agent of the enrollee. Further, a provider may join with, or otherwise assist, an enrollee, or the agent, to submit the grievance to the consumer advocate. In addition, following submission of the grievance to the consumer advocate, the enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the enrollee. For purposes of this section, a "relative" includes the parent, stepparent, spouse, domestic partner, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the enrollee.~~

~~(5) The consumer advocate shall review the written documents submitted with the enrollee's request for review. The consumer advocate may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the enrollee. If after reviewing the record, the consumer advocate concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Section 140609, the consumer advocate shall immediately notify the enrollee of that option and shall, if requested orally or in writing, assist the enrollee in participating in the independent medical review system.~~

~~(6) The consumer advocate shall send a written notice of the final disposition of the grievance, and the reasons therefore, to the enrollee, to any provider that has joined with or is otherwise assisting the enrollee, and to the health care commissioner, within 30 calendar days of receipt of the request for review unless the consumer advocate, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Section 140609, the consumer advocate's written notice shall include, at a minimum, the following:~~

~~(A) A summary of findings and the reasons why the consumer advocate found the system to be, or not to be, in compliance with any applicable laws, regulations, or orders of the commissioner.~~

~~(B) A discussion of the consumer advocate's contact with any medical provider, or any other independent expert relied on by the consumer advocate, along with a summary of the views and qualifications of that provider or expert.~~

~~(C) If the enrollee's grievance is sustained in whole or in part, information about any corrective action taken.~~

~~(7) In any consumer advocate review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 140609, that is not eligible for the independent medical review system established pursuant to Section 140609, in which the consumer advocate finds that the system has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service system contract, the consumer advocate's written notice shall order the system to promptly offer and provide those health care services to the enrollee.~~

~~(A) The consumer advocate's order shall be binding on the system.~~

~~(8) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the consumer advocate be required to testify as to that information or notice.~~

~~(9) The consumer advocate shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.~~

~~(c) Subject to subparagraph (3) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.~~

~~(d) Nothing in this section shall be construed to allow the submission to the consumer advocate of any provider grievance~~

~~under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the consumer advocate about any concerns he or she has regarding compliance with or enforcement of this chapter.~~

~~140609. (a) The consumer advocate shall establish the Independent Medical Review System to act as an independent, external medical review process for the health care system to provide timely examinations of disputed health care services as defined in this section and coverage decisions as defined in this section regarding experimental and investigational therapies to ensure the system provides efficient, appropriate, high quality health care, and that the health care system is responsive to patient disputes.~~

~~(b) For the purposes of this chapter, "disputed health care service" means any health care service eligible for coverage and payment under the benefits package of the health care system that has been denied, modified, or delayed by a decision of the system, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. If the system, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the system, the statement of decision shall clearly specify the provisions of the system that exclude coverage.~~

~~(c) For the purposes of this chapter, "coverage decision" means the approval or denial of the health care system, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care system. A "coverage decision" does not encompass a plan or contracting provider decision regarding a disputed health care service.~~

~~(d) Coverage decisions regarding experimental or investigational therapies for individual enrollees who meet all of~~

~~the following criteria are eligible for review by the Independent Medical Review System:~~

~~(1) (A) The enrollee has a life-threatening or seriously debilitating condition.~~

~~(B) For purposes of this section, "life-threatening" means either or both of the following:~~

~~(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.~~

~~(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.~~

~~(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.~~

~~(2) The enrollee's physician certifies that the enrollee has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the enrollee, or for which there is no more beneficial standard therapy covered by the system than the therapy proposed pursuant to paragraph (3).~~

~~(3) Either (A) the enrollee's physician, who is under contract with or employed by the system, has recommended a drug, device, procedure or other therapy that the physician certifies in writing is likely to be more beneficial to the enrollee than any available standard therapies, or (B) the enrollee, or the enrollee's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in _____, is likely to be more beneficial for the enrollee than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the system to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to system benefits package.~~

~~(4) The enrollee has been denied coverage by the system for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3).~~

~~(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would be a covered service, except for the system's determination that the therapy is experimental or investigational.~~

~~(c) (1) All patient grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the consumer advocate finds that a patient grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the patient request for review shall be treated as a request for the consumer advocate to review the grievance pursuant to Section 140608. All other patient grievances, including grievances involving coverage decisions, remain eligible for review by the consumer advocate pursuant to subdivision (b) of Section 1368.~~

~~(2) In any case in which a patient or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical appropriateness, the consumer advocate shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article or pursuant to Section _____.~~

~~(3) The consumer advocate shall be the final arbiter when there is a question as to whether a patient grievance is a disputed health care service or a coverage decision. The consumer advocate shall establish a process to complete an initial screening of a patient grievance. If there appears to be any medical appropriateness issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article or pursuant to Section _____.~~

~~(f) For purposes of this article, a patient may designate an agent to act on his or her behalf, as described in paragraph (4) of subdivision (b). The provider may join with or otherwise assist the patient in seeking an independent medical review, and may advocate on behalf of the patient.~~

~~(g) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.~~

~~(h) The office of the consumer advocate shall prominently display in every relevant informational brochure, on copies of health care system procedures for resolving grievances, on letters of denials issued by either the health care system or its contracting providers, on the grievance forms, and on all written responses to grievances, information concerning the right of a patient to request an independent medical review in cases where the patient believes that health care services have been improperly denied, modified, or delayed by the health care system, or by one of its contracting providers.~~

~~(i) A patient may apply to the consumer advocate for an independent medical review when all of the following conditions are met:~~

~~(1) (A) The patient's health care provider has recommended a health care service as medically appropriate.~~

~~(B) The patient has received urgent care or emergency services that a provider determined was medically appropriate.~~

~~(C) The patient, in accordance with Section 1370.4 of the Health and Safety Code, seeks coverage for experimental or investigational therapies.~~

~~(D) The patient, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an system provider for the diagnosis or treatment of the medical condition for which the patient seeks independent review. The health care system shall expedite access to a system provider upon request of a patient. The system provider need not recommend the disputed health care service as a condition for the patient to be eligible for an independent review. For purposes of this article, the patient's provider may be an out-of-system provider. However, the health care system shall have no liability for payment of services provided by an out-of-system provider, except as provided pursuant to subdivision (c) of Section 1374.34.~~

~~(2) The disputed health care service has been denied, modified, or delayed by the health care system, or by one of its~~

~~contracting providers, based in whole or in part on a decision that the health care service is not medically appropriate.~~

~~(3) The patient has filed a grievance with the consumer advocate and the disputed decision is upheld or the grievance remains unresolved after 30 days. The patient shall not be required to participate in the health care system's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the patient shall not be required to participate in the health care system's grievance process for more than three days.~~

~~(j) A patient may apply to the consumer advocate for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically appropriate, within six months of any of the qualifying periods or events under subdivision (j). The consumer advocate may extend the application deadline beyond six months if the circumstances of a case warrant the extension.~~

~~(k) The patient shall pay no application or processing fees of any kind.~~

~~(*l*) As part of its notification to the patient regarding a disposition of the patient's grievance that denies, modifies, or delays health care services, the health care system shall follow notification requirements set out in subdivision (m) of the Health and Safety Code.~~

~~(m) Upon notice from the consumer advocate that the patient has applied for an independent medical review, the health care system or its contracting providers shall provide to the independent medical review organization designated by the consumer advocate a copy of all of the following documents within three business days of the health care system's receipt of the consumer advocate's notice of a request by an patient for an independent review:~~

~~(1) (A) A copy of all of the patient's medical records in the possession of the health care system or its contracting providers relevant to each of the following:~~

~~(i) The patient's medical condition.~~

~~(ii) The health care services being provided by the health care system and its contracting providers for the condition.~~

~~(iii) The disputed health care services requested by the patient for the condition.~~

~~(B) Any newly developed or discovered relevant medical records in the possession of the health care system or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The system shall concurrently provide a copy of medical records required by this subparagraph to the patient or the patient's provider, if authorized by the patient, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.~~

~~(2) A copy of all information provided to the patient by the system and any of its contracting providers concerning health care system and provider decisions regarding the patient's condition and care, and a copy of any materials the patient or the patient's provider submitted to the health care system and to the health care system's contracting providers in support of the patient's request for disputed health care services. This documentation shall include the written response to the patient's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any patient medical information shall be maintained pursuant to applicable state and federal laws.~~

~~(3) A copy of any other relevant documents or information used by the health care system or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the system and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The system shall concurrently provide a copy of documents required by this paragraph, except for any information found by the consumer advocate to be legally privileged information, to the patient and the patient's provider. The consumer advocate and the independent review organization shall maintain the confidentiality of any information found by the consumer advocate to be the proprietary information of the health care system.~~

~~140610. (a) If there is an imminent and serious threat to the health of the patient, as specified in subdivision (c) of Section~~

~~1374.33, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the consumer advocate may waive the requirement that the patient follow the system's grievance process in extraordinary and compelling cases, where the consumer advocate finds that the patient has acted reasonably.~~

~~(b) The consumer advocate shall expeditiously review requests and immediately notify the patient in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefore. The health care system shall promptly issue a notification to the patient, after submitting all of the required material to the independent medical review organization that includes an annotated list of documents submitted and offer the patient the opportunity to request copies of those documents from the health care system. The consumer advocate shall promptly approve patient requests whenever the health care system has agreed that the case is eligible for an independent medical review. The consumer advocate shall not refer coverage decisions for independent review. To the extent a patient request for independent review is not approved by the consumer advocate, the patient request shall be treated as an immediate request for the consumer advocate to review the grievance pursuant to subdivision (b) of Section 1368.~~

~~(c) An independent medical review organization, specified in Section 1374.32 of the Health and Safety Code, shall conduct the review in accordance with Section 1374.33 and any regulations or orders of the consumer advocate adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.~~

~~(d) The consumer advocate shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of the health care system. The consumer advocate may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be~~

~~required to meet in order to qualify for participation in the Independent Medical Review System and to assist the consumer advocate in carrying out its responsibilities.~~

~~(e) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.~~

~~(f) The independent medical review organization, any experts it designates to conduct a review, or any officer, consumer advocate, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the consumer advocate, with any of the following:~~

~~(1) The health care system.~~

~~(2) Any officer, consumer advocate, or employee of the health care system.~~

~~(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.~~

~~(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the health care system, would be provided.~~

~~(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the patient whose treatment is under review, or the alternative therapy, if any, recommended by the health care system.~~

~~(6) The patient or the patient's immediate family.~~

~~(g) In order to contract with the consumer advocate for purposes of this article, an independent medical review organization shall meet all of the requirements pursuant to subdivision (d) of Section 1374.32 of the Health and Safety Code.~~

~~140611. (a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the patient, provider reports, as well as any other information submitted to the organization as authorized by the consumer advocate or requested from any of the parties to the dispute by the reviewers. If reviewers request information from~~

~~any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).~~

~~(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically appropriate based on the specific medical needs of the patient and any of the following:~~

~~(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.~~

~~(2) Nationally recognized professional standards.~~

~~(3) Expert opinion.~~

~~(4) Generally accepted standards of medical practice.~~

~~(5) Treatments likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.~~

~~(c) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the consumer advocate. If the disputed health care service has not been provided and the patient's provider or the consumer advocate certifies in writing that an imminent and serious threat to the health of the patient may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the patient, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the consumer advocate, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the consumer advocate for up to three days in extraordinary circumstances or for good cause.~~

~~(d) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically appropriate. Each analysis shall cite the patient's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall~~

~~prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.~~

~~(e) The independent medical review organization shall provide the consumer advocate, the health care system, the patient, and the patient's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.~~

~~(f) The consumer advocate shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the health care system.~~

~~(g) After removing the names of the parties, including, but not limited to, the patient, all medical providers, the health care system, and any of the insurer's employees or contractors, consumer advocate decisions adopting a determination of an independent medical review organization shall be made available by the consumer advocate to the public upon request, at the consumer advocate's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.~~

~~140612. (a) Upon receiving the decision adopted by the consumer advocate pursuant to subdivision (e) of Section 140609 that a disputed health care service is medically appropriate, the health care system shall promptly implement the decision. In the case of reimbursement for services already rendered, the health care system shall reimburse the provider or patient, whichever applies, within five working days. In the case of services not yet rendered, the health care system shall authorize the services within five working days of receipt of the written decision from the consumer advocate, or sooner if appropriate for the nature of~~

~~the patient's medical condition, and shall inform the patient and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.~~

~~(b) The health care system shall not engage in any conduct that has the effect of prolonging the independent review process.~~

~~(c) The consumer advocate shall require the health care system to promptly reimburse the patient for any reasonable costs associated with those services when the consumer advocate finds that the disputed health care services were a covered benefit pursuant to this division, and the services are found by the independent medical review organization to have been medically appropriate pursuant to Section 1374.33, and either the patient's decision to secure the services outside of the health care system provider network was reasonable under the emergency or urgent medical circumstances, or health care system does not require or provide prior authorization before the health care services are provided to the patient.~~

~~(d) In addition to requiring system compliance regarding subdivisions (a), (b), and (c) the consumer advocate shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an patient has already occurred because of the decision of the health care system, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically appropriate pursuant to Section 1374.33, the consumer advocate shall impose penalties.~~

~~(e) Pursuant to Section 1368.04, the consumer advocate shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the consumer advocate, particularly if the health care system repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically appropriate health care services when the obligation of the health care system to provide those health care services to patients or subscribers is reasonably clear.~~

~~140613. (a) The consumer advocate shall utilize a competitive bidding process and use any other information on~~

~~program costs reasonable to establish a per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.~~

~~(b) The costs of the independent medical review system for enrollees shall be borne by the health care system.~~

140608. (a) The consumer advocate shall establish a grievance system for all grievances except those involving the delay, denial, or modification of health care services. The consumer advocate shall do the following with regard to the grievance system:

(1) Establish and maintain a grievance system approved by the health care commissioner under which members of the system may submit their grievances to the system. The system shall provide reasonable procedures that shall ensure adequate consideration of member grievances and rectification when appropriate.

(2) Inform members of the system upon enrollment in the system and annually hereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide printed and electronic access for members who wish to register grievances. The forms used by the system shall be approved by the commissioner in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the system representative and the telephone number and address of the system representative who may be contacted about the grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or online through the system's Web site that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The consumer advocate shall maintain a log of all these grievances.

The log shall be periodically reviewed by the consumer advocate and shall include the following information for each complaint:

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's system identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the system representative who took the call and resolved the grievance.

(5) Provide members of the system with written responses to grievances, with a clear and concise explanation of the reasons for the system's response.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(7) Establish and maintain a Web site that shall provide an online form that members of the system can use to file with a grievance online.

(b) The consumer advocate may refer any grievance that does not pertain to compliance with this division to the federal Health Care Financing Administration, or any other appropriate local, state, and federal governmental entity for investigation and resolution.

(c) If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the grievance to the consumer advocate as a designated agent of the member. Further, a provider may join with, or otherwise assist, an enrollee, or the agent, to submit the grievance to the consumer advocate. In addition, following submission of the grievance to the consumer advocate, the member, or the agent, may authorize the provider to assist, including advocating on behalf of the member. For purposes of this section, a "relative" includes the parent, stepparent, spouse, domestic partner, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the member.

(d) The consumer advocate shall review the written documents submitted with the member's request for review. The consumer advocate may ask for additional information, and may hold an informal meeting with the involved parties, including providers

who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the member.

(e) The consumer advocate shall send a written notice of the final disposition of the grievance, and the reasons therefore, to the member, to any provider that has joined with or is otherwise assisting the member, and to the commissioner, within 30 calendar days of receipt of the request for review unless the consumer advocate, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. The consumer advocate's written notice shall include, at a minimum, the following:

(1) A summary of findings and the reasons why the consumer advocate found the system to be, or not to be, in compliance with any applicable laws, regulations, or orders of the commissioner.

(2) A discussion of the consumer advocate's contact with any medical provider, or any other independent expert relied on by the consumer advocate, along with a summary of the views and qualifications of that provider or expert.

(3) If the member's grievance is sustained in whole or in part, information about any corrective action taken.

(f) The consumer advocate's order shall be binding on the system.

(g) The consumer advocate shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

140610. The chief medical officer shall establish a grievance system for all grievances involving the delay, denial, or modification of health care services. The chief medical officer shall do all of the following with regard to the grievance regarding delay, denial, or modification of health care services:

(1) Establish and maintain a grievance system approved by the health care commissioner under which members of the system may submit their grievances to the system. The system shall provide reasonable procedures that shall ensure adequate consideration of member grievances and rectification when appropriate.

(2) Inform members of the system upon enrollment in the system and annually hereafter of the procedure for processing

and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide printed and electronic access for members who wish to register grievances. The forms used by the system shall be approved by the commissioner in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance. The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the system representative and the telephone number and address of the system representative who may be contacted about the grievance.

(B) The chief medical officer shall maintain a log of all these grievances. The log shall be periodically reviewed by the chief medical officer and shall include the following information for each complaint:

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's system identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the system representative who took the call and resolved the grievance.

(5) Provide members of the system with written responses to grievances, with a clear and concise explanation of the reasons for the system's response. The system response shall describe the criteria used and the clinical reasons for its decision including all criteria used and the clinical reasons for its decision including all criteria and clinical reasons related to medical necessity.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(7) Establish and maintain a Web site that shall provide an online form that members of the system can use to file with a grievance online.

(b) In any case determined by the chief medical officer to be a case involving an imminent and serious threat to the health of the member, including, but not limited to, severe pain, the potential

loss of life, limb, or major bodily function, or in any other case where the chief medical officer determines that an earlier review is warranted, a member shall not be required to complete the grievance process.

(c) If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the grievance to the chief medical officer as a designated agent of the member. Further, a provider may join with, or otherwise assist, an enrollee, or the agent, to submit the grievance to the chief medical officer. In addition, following submission of the grievance to the chief medical officer, the member, or the agent, may authorize the provider to assist, including advocating on behalf of the member. For purposes of this section, a "relative" includes the parent, stepparent, spouse, domestic partner, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the member.

(d) The chief medical officer shall review the written documents submitted with the member's request for review. The chief medical officer may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the member. If after reviewing the record, the chief medical officer concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system, the chief medical officer shall immediately notify the member of that option and shall, if requested orally or in writing, assist the member in participating in the independent medical review system.

(e) The chief medical officer shall send a written notice of the final disposition of the grievance, and the reasons therefore, to the member, to any provider that has joined with or is otherwise assisting the member, and to the commissioner, within 30 calendar days of receipt of the request for review unless the chief medical officer, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for independent medical review, the chief medical officer's written notice shall include, at a minimum, the following:

(1) A summary of findings and the reasons why the chief medical officer found the system to be, or not to be, in compliance with any applicable laws, regulations, or orders of the commissioner.

(2) A discussion of the chief medical officer's contact with any medical provider, or any other independent expert relied on by the consumer advocate, along with a summary of the views and qualifications of that provider or expert.

(3) If the member's grievance is sustained in whole or in part, information about any corrective action taken.

(f) The chief medical officer's order shall be binding on the system.

(g) The chief medical officer shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(h) The grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(i) Nothing in this section shall be construed to allow the submission to the chief medical officer of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the chief medical officer about any concerns he or she has regarding compliance with or enforcement of this act.

140612. (a) The chief medical officer shall establish an independent medical review system to act as an independent, external medical review process for the health care system to provide timely examinations of disputed health care services and coverage decisions regarding experimental and investigational therapies to ensure the system provides efficient, appropriate, high quality health care, and that the health care system is responsive to member disputes.

(b) For the purposes of this section, "disputed health care service" means any health care service eligible for coverage and payment under the benefits package of the health care system that has been denied, modified, or delayed by a decision of the system, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. If the system, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the system, the statement of decision shall clearly specify the provisions of the system that exclude coverage.

(c) For the purposes of this section, "coverage decision" means the approval or denial of the health care system, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care system.

(d) Coverage decisions regarding experimental or investigational therapies for individual members who meet all of the following criteria are eligible for review by the independent medical review system:

(1) (A) The member has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, "life-threatening" means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

(2) The member's physician certifies that the member has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the member, or for which there is no

more beneficial standard therapy covered by the system than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the member's physician, who is under contract with or employed by the system, has recommended a drug, device, procedure or other therapy that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (B) the member, or the member's physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial for the member than any available standard therapy. The physician certification pursuant to this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the system to pay for the services of a nonparticipating physician provided pursuant to this act, that are not otherwise covered pursuant to system benefits package.

(4) The member has been denied coverage by the system for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3).

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would be a covered service, except for the system's determination that the therapy is experimental or investigational.

(e) (1) All member grievances involving a disputed health care service are eligible for review under the independent medical review system if the requirements of this section are met. If the chief medical officer finds that a patient grievance involving a disputed health care service does not meet the requirements of this section for review under the independent medical review system, the enrollee request for review shall be treated as a request for the chief medical officer to review the grievance. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the chief medical officer.

(2) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical

appropriateness, the chief medical officer shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this act.

(3) The chief medical officer shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The chief medical officer shall establish a process to complete an initial screening of an enrollee grievance. If there appears to be any medical appropriateness issue, the grievance shall be resolved pursuant to an independent medical review.

(f) For purposes of this article, an enrollee may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the enrollee in seeking an independent medical review, and may advocate on behalf of the enrollee.

(g) The independent medical review process authorized by this section is in addition to any other procedures or remedies that may be available.

(h) The office of the chief medical officer shall prominently display in every relevant informational brochure, on copies of health care system procedures for resolving grievances, on letters of denials issued by either the health care system or its contracting providers, on the grievance forms, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the health care system, or by one of its contracting providers.

(i) An enrollee may apply to the chief medical officer for an independent medical review when all of the following conditions are met:

(1) (A) The enrollee's health care provider has recommended a health care service as medically appropriate.

(B) The enrollee has received urgent care or emergency services that a provider determined was medically appropriate.

(C) The enrollee, in accordance with Section 1370.4 of the Health and Safety Code, seeks coverage for experimental or investigational therapies.

(D) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent

care or emergency services by a provider under subparagraph (B), has been seen by an system provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The health care system shall expedite access to a system provider upon request of an enrollee. The system provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

(2) The disputed health care service has been denied, modified, or delayed by the health care system, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically appropriate.

(3) The enrollee has filed a grievance with the chief medical officer and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the health care system's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the enrollee shall not be required to participate in the health care system's grievance process for more than three days.

(j) An enrollee may apply to the chief medical officer for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically appropriate, within six months of any of the qualifying periods or events. The chief medical officer may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(k) The enrollee shall pay no application or processing fees of any kind.

(l) Upon notice from the chief medical officer that the enrollee has applied for an independent medical review, the health care system or its contracting providers shall provide to the independent medical review organization designated by the chief medical officer a copy of all of the following documents within three business days of the health care system's receipt of the chief medical officer's notice of a request by an enrollee for an independent review:

(1) (A) A copy of all of the enrollee's medical records in the possession of the health care system or its contracting providers relevant to each of the following:

(i) The enrollee's medical condition.

(ii) The health care services being provided by the health care system and its contracting providers for the condition.

(iii) The disputed health care services requested by the enrollee for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the health care system or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The system shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the enrollee by the system and any of its contracting providers concerning health care system and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the health care system and to the health care system's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the health care system or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the system and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The system shall concurrently provide a copy of documents required by this paragraph, except for any information found by the chief medical officer to be legally

privileged information, to the enrollee and the enrollee's provider.

The chief medical officer and the independent review organization shall maintain the confidentiality of any information found by the chief medical officer to be the proprietary information of the health care system.

140614. (a) If there is an imminent and serious threat to the health of the enrollee, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the chief medical officer may waive the requirement that the enrollee follow the system's grievance process in extraordinary and compelling cases, where the chief medical officer finds that the enrollee has acted reasonably.

(b) The chief medical officer shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefore. The health care system shall promptly issue a notification to the enrollee, after submitting all of the required material to the independent medical review organization that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those documents from the health care system. The chief medical officer shall promptly approve enrollee requests whenever the health care system has agreed that the case is eligible for an independent medical review. To the extent an enrollee request for independent review is not approved by the chief medical officer, the enrollee request shall be treated as an immediate request for the chief medical officer to review the grievance.

(c) An independent medical review organization, specified in Section 1374.32 of the Health and Safety Code, shall conduct the review in accordance with Section 1374.33 and any regulations or orders of the chief medical officer adopted pursuant thereto. The organization's review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.

(d) The chief medical officer shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this section. The independent medical review organizations shall be independent of the health care system. The chief medical officer may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this section that an organization shall be required to meet in order to qualify for participation in the independent medical review system and to assist the chief medical officer in carrying out its responsibilities.

(e) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(f) The independent medical review organization, any experts it designates to conduct a review, or any officer, chief medical officer, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the consumer advocate, with any of the following:

(1) The health care system.

(2) Any officer or employee of the health care system.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the health care system, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the patient whose treatment is under review, or the alternative therapy, if any, recommended by the health care system.

(6) The enrollee or the enrollee's immediate family.

(g) In order to contract with the chief medical officer for purposes of this section, an independent medical review organization shall meet all of the requirements pursuant to subdivision (d) of Section 1374.32 of the Health and Safety Code.

140616. (a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review

organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the chief medical officer or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically appropriate based on the specific medical needs of the patient and any of the following:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

(5) Treatments likely to provide a benefit to an enrollee for conditions for which other treatments are not clinically efficacious.

(c) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the chief medical officer. If the disputed health care service has not been provided and the enrollee's provider or the chief medical officer certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the chief medical officer, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the chief medical officer for up to three days in extraordinary circumstances or for good cause.

(d) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically appropriate. Each analysis shall cite the enrollee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(e) The independent medical review organization shall provide the chief medical officer, the health care system, the enrollee, and the enrollee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(f) The chief medical officer shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the health care system.

(g) After removing the names of the parties, including, but not limited to, the enrollee and all medical providers, the chief medical officer's decisions adopting a determination of an independent medical review organization shall be made available by the chief medical officer to the public upon request, at the chief medical officer's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

140618. (a) Upon receiving the decision adopted by the chief medical officer that a disputed health care service is medically appropriate, the health care system shall promptly implement the decision. In the case of reimbursement for services already

rendered, the health care provider or enrollee, whichever applies, shall be paid within five working days. In the case of services not yet rendered, the health care system shall authorize the services within five working days of receipt of the written decision from the chief medical officer, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization.

(b) The health care system shall not engage in any conduct that has the effect of prolonging the independent review process.

(c) The chief medical officer shall require the health care system to promptly reimburse the enrollee for any reasonable costs associated with those services when the chief medical officer finds that the disputed health care services were a covered benefit and the services are found by the independent medical review organization to have been medically appropriate and the enrollee's decision to secure the services outside of the health care system provider network was reasonable under the emergency or urgent medical circumstances.

140619. (a) The chief medical officer shall utilize a competitive bidding process and use any other information on program costs reasonable to establish a per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) The costs of the independent medical review system for enrollees shall be borne by the health care system.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

CORRECTIONS:

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